Patient Quality, Safety & Outcomes Committee

Tue 21 December 2021, 09:00 - 12:00

Microsoft Teams

Agenda

09:00 - 09:10
10 min

1. Preliminary Matters

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Draft Minutes of the Committee held on 19th October 2021

Attachment *Chair*

1.4 Approved Draft Minutes PQSOC 19.10.21.pdf (11 pages)

1.5. Action Sheet of the Committee held on 19th October 2021

Attachment *Chair*

1.5 - Action Sheet PQSC 191021 Approved.pdf (3 pages)

09:10 - 10:40
90 min

2. Presentations/Reports for Assurance

2.1. 9:10-9:30 Urgent and Emergency Care Update

Attachment *Director of Operations*

2.1 Urgent Care Improvement Plan - December 2021.pdf (13 pages)

2.2. 9:30-9:50 Minor Injuries Units eLGHs

Presentation-to follow *Medical Director/Director of Nursing*

2.3. 9:50-10:10 External Inspections & Reviews: Healthcare Inspectorate Wales & the Aneurin Bevan CHC- HIW National Ambulance Review, HIW GUH ED & Assessment Units, CHC 7 Days in ED, HIW Mental Health St Cadocs and Wales Neonatal Network Peer Review

Attachments *Director of Nursing*

2.3 PQSOC Inspections Report - November 2021.pdf (5 pages)
2.3a APPENDIX 1 - ABUHB Management Response - HIW Review of Patient Experience during delayed ambulance handover.pdf (7 pages)
2.3b APPENDIX 2 - ABUHB Management Response - CHC 7 days in the Emergency Department.pdf (3 pages)
2.3c Appendix 3 Neonatal review.pdf (7 pages)

2.4. 10:10-10:20 Learning from Death Report

Attachment *Medical Director*

2.4 Learning from Death 20211115.pdf (22 pages)

2.5. 10:20-10:30 Cleaning Standards Report- Performance against standards

Attachment *Director of Operations*

2.5 Cleaning Standards Report- Performance against standards PQSOC 2021.pdf (3 pages)
2.5a Updated Exec Team SBAR Update Enhanced Cleaning Standards on 23.09.21.pdf (9 pages)

2.6. 10:30-10:40 Break

10:40 - 11:40
60 min

3. For Consideration

3.1. 10:40-10:50 Update of QPSOG

Attachment *Director of Therapies & Health Sciences*

3.1 QPSOG report from 10 11 2021.pdf (3 pages)

3.2. 10:50-11:20 Quality and Safety Outcomes Report

Attachment *Clinical Executives*

3.2 PQSOC Performance Report December 2021.pdf (24 pages)

3.3. 11:20-11:40 WCCIS Implementation

Attachment *Janice Jenkins*

3.3 PQSO WCCIS Update_2112_v2.0.pdf (6 pages)
3.3a WCCIS Risk Profile.pdf (2 pages)

11:40 - 11:50
10 min

4. Items for Quality Assurance- for information

4.1. 11:40-11:50 Highlight Reports:

4.1.1. Safeguarding Committee

Attachment *Director of Nursing*

4.1.1 Safeguarding Highlight Report - December 2021.pdf (4 pages)

4.1.2. Urgent Care Transformation Board

Attachment *Director of Operations*

4.1.2 Urgent Care Transformation Highlight Report Nov 21.pdf (1 pages)

11:50 - 12:00
10 min

5. Items for Board Consideration

5.1. Strategic Risk Report (Key Risks)

Attachment *Board Secretary*

5.1 PQSO Committee Risk Report Dec2021 V1.pdf (7 pages)

5.1a Appendix 1 PQSO Committee Dec2021.pdf (11 pages)

5.1.1. Agenda Items

Verbal *Chair*

5.1.2. Confirm key risks and items for Board consideration

Verbal *Chair*

12:00 - 12:00
0 min

6. Date of Next Meeting is Tuesday 8th February 2021 at 09:30 via Microsoft Teams

Aneurin Bevan University Health Board

Patient Quality Safety and Outcomes Committee

Minutes of the Meeting of the Patient Quality Safety and Outcomes Committee held on Tuesday, 19th October 2021, via Microsoft Teams

Present:

Pippa Britton	-	Independent Member (Chair)
Paul Deneen	-	Independent Member
Helen Sweetland	-	Independent Member
Shelley Bosson	-	Independent Member
Louise Wright	-	Independent Member

In attendance:

Rhiannon Jones	-	Director of Nursing
Peter Carr	-	Director of Therapies and Health Science
Richard Howells	-	Interim Board Secretary
Lucy Windsor	-	Corporate Services Manager

Apologies:

Judith Paget	-	Chief Executive
James Calvert	-	Medical Director

Observers:

Ann Lloyd	-	Observer, ABUHB Chair
James Quance	-	Observer, Internal Audit
Tracey Partridge-Wilson	-	Observer, Assistant Director of Nursing
Nathan Couch	-	Observer, Audit Wales
Alexandra Scott	-	Observer, Assistant Director Patient Safety
Phil Robson	-	Special Advisor to the Board
Alan Davies	-	Observer, Aneurin Bevan Community Health Council

PQSOC 1910/01 Welcome and Introductions

The Chair welcomed everyone to the meeting.

PQSOC 1910/02 Apologies for Absence

The apologies for absence were noted.

PQSOC 1910/03 Declarations of Interest

There were no declarations of interest in relation to the items on the agenda.

PQSOC 1910/04 Draft Minutes of the Meeting held on 1st September 2021

The minute for 0109/08 PTR Annual Report 2020/2021 to be amended to:

'It was agreed that an Annual Report and a 6-month mid-year review would be provided.'

PQSOC 1910/05 Action Sheet of the Committee held on 1st September 2021 – updates.

1506/07 Assurance Process for Complex Care and CHC
A letter has been sent to HIW outlining issues with a helpful and informative response received.

0109/11 – Medical Devices
The Action Plan is scheduled for ratification at the Medical Devices Committee. Once approved it will be provided to the PQSOC.

PQSOC 1910/06 Dementia Companions and Meaningful Occupation model: Update on the Proof of Concept Model and Service Evaluation at Ysbty Aneurin Bevan

Rhiannon Jones provided an update noting progress had not advanced as expected despite huge appetite for the initiative. This was due to service pressures affecting the ability to release staff for training; a resolution had been sought and a different approach to training implemented.

The Committee was informed that a multidisciplinary Steering Group had been established, volunteers appointed and Kings Fund Environmental Auditing had been undertaken. Dementia and associated training had been delivered and funding for two practice educators had been secured to support the roll out of this agenda.

Rhiannon Jones was anticipative that a full evaluation would be available at the next Committee meeting, but noted it would be dependent on commencement of the companions, as there had been delays with some start dates because of individuals COVID risk assessment score.

Shelley Bosson was supportive of the coloured walking frames concept and asked why the PoC had not yet been rolled out in YAB? Rhiannon Jones advised that a meeting to progress implementation of the coloured walking frames in YAB and other hospital sites is scheduled for later that week. An update following the meeting would be provided to committee members.
Action: Rhiannon Jones

The Chair suggested gathering feedback from staff after the training to identify where it could be improved and made more efficient. She also suggested communicating the

successes of the coloured frames to nursing homes and the wider community.

Paul Deneen suggested using the CHC and partners to share good practice and information in creative, innovative ways with other Community Health Councils and Boards to scale up initiatives.

The Committee was encouraged by the support for the PoC and thanked Rhiannon Jones for the report. A further update to be scheduled at the next meeting.
Action: Rhiannon Jones

PQSOC 1910/07 Infection Prevention & Control - update against 2021/2022 priorities

Rhiannon Jones provided an update on progress against the priorities noting a RAG rating had been adopted to demonstrate the current position of the 11 priorities, of which no priorities were RAG rated red and there were no concerns regarding full implementation.

Rhiannon Jones reported a concern about cleaning due to workforce issues within Facilities coupled with demand and capacity pressures. Both factors had challenged the Health Board's ability to carry out the proactive HPV cleaning programme as per the plan. Alternative approaches had been considered however the Committee was informed that these would not be as impactful as full compliance to the proactive cleaning programme.

The Executive Team had recently agreed investment, and Workforce and OD support to fast track recruitment; noting the timeline of 3 months for staff to commence employment and be appropriately trained.

Rhiannon Jones reported COVID-19 & PTR (the claims agenda) as another area of focus. To date the Health Board had made good progress in reviewing cases of nosocomial transmission through robust outbreak reviews. A proposal for future management of reviews is in-development but noted the Assistant Director of Nursing (Liz Waters) was retiring this week; this would affect the ability to make further rapid progress in this area.

Rhiannon Jones assured the Committee that where patients and families had made a complaint the Health Board had complied with the PTR process.

The Committee was informed of the proposed Delivery Unit 'review' process noting the extensive and significant

implications for how the Health Board could comply with the approach. Medical Directors and Executive Directors of Nursing are due to meet the Chief Nursing Officer and Chief Medical Officer to outline concerns..

Rhiannon Jones acknowledged the retirement of Liz Waters after 42 years in the NHS and 22 years as an Infection Control Nurse.

The Chair on behalf of the Board thanked Liz Waters for her exemplary service and wished her well in her retirement. A letter will be sent to Liz Waters from the Chair of the PQSOC.

Shelley Bosson requested assurance on how the Facilities team is meeting the new cleaning standards and the mitigation in place, recognising that the proactive programme of HPV cleaning is not consistently being implemented. Rhiannon Jones advised that a modelling tool had been used to determine the gaps and recruitment needed based on the size and cleaning requirements of wards/rooms. The data collected was used to inform the investment paper provided to Executive Team.

Rhiannon Jones reassured the Committee that core standards and the ability to ensure regular touch point cleaning are being met.

A report outlining progress against cleaning standards – pre and post implementation of the new standards including the investment required and recruitment challenges would be scheduled for the next Committee meeting.
Action: Secretariat / Leanne Watkins (Director of Operations)

The Committee was apprised of the alternative structure for infection, prevention, and control following Liz Waters' retirement. Rhiannon Jones advised that further recruitment would be required and noted, through the transformation funding, the community IPAC provision had been strengthened to support the independent sector and care homes with a further bid being progressed to continue the provision.

The Committee noted the good progress being made against the 2021/2022 priorities.

PQSOC 1910/08 PTR Annual Report 2020/2021 Update against Priorities

The Committee received an update, from Rhiannon Jones, on the progress against the nine PTR priorities noting all had made good progress. No priorities were RAG rated red and there were no concerns regarding full implementation of the priorities.

It was noted that the Claims, Redress, and Feedback module of RL Datix application went live at the beginning of October with the second part due to go live in December.

The first PTR Newsletter would be launched this month and shared with committee members.
Action: Rhiannon Jones

The Chair asked whether a formalised feedback process was in place to capture how the service had dealt with complainants concerns. Rhiannon Jones provided reassurance that feedback was captured via the CHC and multiple surveys. To strengthen real time patient feedback the Health Board is looking to procure the feedback module that is part of the RLDatix system.

The Committee noted the good progress being made against the 2021/ 2022 priorities.

PQSOC1910/09 Safeguarding Annual Report 2020/2021

Rhiannon Jones presented the Safeguarding Annual Report noting its purpose was to provide an overview on how the Health Board had managed Safeguarding during 2020/2021; as well as a mechanism for highlighting safeguarding as a key priority.

The Committee was informed of the progress that had been made, performance successes, learning and an overview of emerging themes and trends. An outline of the governance infrastructure, audit and assurance, metrics and outcomes was also provided. The report also highlighted the importance of multi-agency working and the multiple groups in existence, locally, regionally, and nationally.

Rhiannon Jones shared the key learning from surge 1 of the pandemic that informed a different approach for deployment in surge 2, in particular protecting the deployment of staff working in essential children's services. This approach saw a reduction in child protection medicals and children being referred but noted a rise in domestic abuse, particularly associated with lockdown.

Rhiannon Jones extended her gratitude to the ABUHB Safeguarding Team who had worked tirelessly and creatively during the pandemic and had provided proactive support to

divisions, to include the establishment of a Single Point of Access for referrals.

The challenges surrounding recruitment of paediatric consultants was reported as continuing but noted discussions were being held to mitigate risk to the service and to find a resolution.

Shelley Bosson requested assurance on actions to improve training compliance, noting the low compliance of medical, dental and works and estates staff. Rhiannon Jones advised that a Senior Nurse for Safeguarding Education had been appointed and would be making direct contact with teams reporting low compliance. Rhiannon Jones would link with the Board Secretary to arrange bespoke training for Board members that did not attend the focussed Development session.

The Committee was encouraged by the breadth of work being progressed and thanked Rhiannon Jones for the comprehensive report.

PQSOC 1910/10 Quality Assurance Framework – Update

Rhiannon Jones provided an overview of the process and the reporting arrangements to the PQSO Committee and its respective sub groups.

The revised framework and annual cycle of business would ensure strengthened reporting against the Health and Care Standards with dedicated reports scheduled at each committee. In addition, the Performance and Outcomes report demonstrated the alignment of each element to the relevant standards, as well as taking a risk-based approach.

The Committee requested that areas RAG rated 'red' be reported to the committee at every meeting and those 'amber' by exception when changed. It was agreed that the clinical executives along with the Chair would meet to discuss reshaping the agenda to ensure a more proportionate approach to reporting, especially through the Winter period.

The Committee endorsed the approach but going forward would like a slightly revised format of reports to show the key areas of focus.

PQSOC 1910/11 Update from QPSOG

Peter Carr provided an update from the QPSOG meeting held on 30th September 2021 and noted the following items were discussed:

- Radiology had completed all of the actions and recommendations from the HIW inspection conducted 2 years ago
- Dementia Companions PoC Update
- Nutrition and Hydration Update
- Health & Safety Legislative Assurance Framework
- Transport arrangements for inter-site transport
- Blood management assurance

The Committee noted the update.

PQSOC 1910/12 Quality and Safety Outcomes Report (Linked to Health & Care Standards)

Rhiannon Jones supported by Peter Carr presented the Performance Report, which highlighted the current position against a range of key quality indicators and identified emerging themes, areas of concern and mitigation, as well as good practice.

The following key issues were noted:

- Infection Prevention and Control - more specifically C.Diff
- Improved position of complaint response rates from 30% to maintaining a >75%
- CHC and HIW inspections of mental health wards

The Urgent Care Transformation plan had been revised in line with current pressures. An Executive-to-Executive meeting between the Health Board and WAST was being pursued to look at alternative approaches to managing ambulance wait times – noting WAST had established a new clinical safety plan.

A revised escalation process for the Health Board is being drafted recognising the current environment, which is both COVID associated and the impact of non-COVID harm and aligned to the Winter Plan. Committee members requested that the governance arrangements and accountability of the plan should be given due consideration to ensure the Health Board and partner organisations are clear in their role and responsibility for delivering the plan.

Paul Deneen and Shelley Bosson asked for assurance on the mitigation in place to ensure patients were not coming to further harm because of a deficit in Radiologists. Peter Carr reassured members that alternative solutions were in place or being progressed and noted that the Health Board follows an all Wales approach whereby radiology reporting is outsourced and specialist input is sought as required.

Further initiatives are being progressed nationally to develop alternatives to medical radiologists and advised that the Health Board is developing its reporting radiographer workforce.

The Committee noted the report.

PQSOC 1910/13 Annual Assurance Report on Health & Care Standards: Nutrition and Hydration

Peter Carr presented the report and advised that the Nutrition and Hydration Steering Group oversee the agenda, which report reports to the Quality, Patient Safety Operational Group.

The Committee was advised of the draft action plan outlining the compliance issues and the timeframes to addressing the issues, noting that the opening of the Grange and the pandemic were key factors in the variation in compliance. The plans purpose is to reduce the variation in compliance, improve operational delivery arrangements across hospital sites in respect of ordering food, identifying feeding needs, access to nutrition and hydration and protected mealtimes.

Peter Carr informed members that the Health Board is not meeting NICE best practice model regarding a dedicated nutritional support team to include specialist nurses. A business case for a dedicated nutritional support team is being developed and would be presented to the Executive Team for consideration, with an update to the Committee.

In addition, a full catering review across the Health Board footprint would commence in October and would take approximately 6 months. It was agreed an outcome report would be agendered for the Committee upon completion mid 2022.
Action: Peter Carr / Secretariat

Shelley Bosson requested clarity on the variation in the admission assessment in Mental Health and community settings. Rhiannon Jones advised that this maybe due to the rollout plan which focused on acute areas in the first instance but would confirm this.
Action: Rhiannon Jones

Paul Deneen queried why the equality impact assessment was reported as not applicable. Peter Carr advised it was an oversight and agreed to amend and reissue the report via the secretariat.

Action: Peter Carr / Secretariat

The Committee noted the report and the action plan.

PQSOC 1910/14 Annual Assurance Report on Health & Care Standards:

Alex Scott, on behalf of James Calvert, presented the report noting that the Health Board had established governance systems in place overseen by the Hospital Transfusion Committee (HTC) to maintain safe transfusion and sufficient supply of blood and all blood components. The HTC oversees, develops and monitors policies, procedures, and guidelines to ensure a standardised approach to blood management.

Effective management of blood is subject to monitoring and performance management at national levels and all health boards work collaboratively with the Welsh Blood Service to ensure proactive and prudent approach to blood management.

Alex Scott advised that the same level of scrutiny applies to the regulation and governance around blood transfusion noting a zero tolerance approach was in place.

The Committee was informed that the recording of training requirements, training, delivery, and competency assessments on ESR is being explored. Furthermore, advancements in digital solutions were contributing to improving patient safety and removing the risk of human error. Discussions at a national level are ongoing regarding the implementation of scan for safety technology.

An action plan overseen by the HTC had been put in place. The Committee would receive a report on an annual basis or where required by exception.

The Chair noted the issue around ESR compliance for staff training and suggested the People and Culture Committee take staff training and compliance forward more broadly.
Action: Secretariat

Paul Deneen requested numbering the action plan and to include examples of patient safety instances and the lessons learnt. Alex Scott agreed to take this forward and add further detail to the action plan.

PQSOC 1910/15 Health Inspectorate Wales Report:

The Committee noted the strengthened relationship between the Health Board and HIW and that the report had been taken to the Executive Team with a letter sent to HIW in response.

A key area for the Health Board is the Manual & Statutory training compliance. Rhiannon Jones provided assurance advising that a review of mandatory and statutory training is being conducted with a view to streamlining the mandatory elements.

PQSOC 1910/16 Highlight Reports

The Committee noted the following reports:

- **Safeguarding Committee**
  The Committee noted the work on the Safeguarding Maturity Matrix, which would be presented to the Executive Team ahead of submission to the National Safeguarding Team.

- **Urgent Care Transformation Group**

The Committee noted the update in respect of urgent and emergency care. This remains a high risk, with significant pressures across health and care, impacting on timely care, safe care and patient experience. Rhiannon Jones informed the Committee that Welsh Government was meeting with Health Board Executive Teams to discuss Winter Plans and system resilience. Members were also informed of the HIW Ambulance review and CHC Report following a review of ED, GUH. Both reports and organisational responses will be shared at the next Committee.

Shelley Bosson requested a detailed update on urgent and emergency care at the next Committee.
Action: Secretariat / Nick Wood

PQSOC 1910/17 National Clinical Audits Action Tracker

The Committee received the improvement plan and noted a National Clinical Audit Report would be presented to the committee bi-annually. The next report would be shared early 2022 with an update against the action plan.

PQSOC 1910/18 Forward Work Programme

The Committee was encouraged to see links to the principle risks and Health and Care Standards as a driver to informing the agenda.

Shelley Bosson suggested that the Forward Work Programme be received at each meeting for comment and to gain assurance that the principal risks are being

progressed. This would also provide an opportunity to agree agenda items based on risks of concern.

Shelley Bosson requested an update Welsh Community Care Information System (WCCIS) at the next Committee meeting but it was agreed this would be for the Strategy, Planning, Partnerships and Wellbeing meeting.

PQSOC 1910/19 Items for Board Consideration

No items required escalation to the Board. It was agreed the Safeguarding Annual Report would be included in the PQSOC update for Board.

Rhiannon Jones apprised the Committee on the recent significant staffing challenges within the midwifery service that led to the centralisation of services for a period of 2 weeks to mitigate the risk of any adverse events occurring. The service had since returned to normal business.

PQSOC 1910/20 Date of the Next Meeting

It was confirmed that the next meeting of the Committee would be held on Tuesday 7th December 2021 via Microsoft Teams.

Patient Quality, Safety & Outcomes Committee
Tuesday 7th December 2021

Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the Quality & Patient Safety Committee and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the Quality & Patient Safety Committee these actions will be taken off the rolling action sheet.)

Agreed Actions:

Outstanding	In Progress	Complete

Minute Ref:	Agenda Item	Agreed Action	Lead	Progress/ Completed
QPSC 1304/05		A Matrix of Committee Duties to come to a future meeting (1102/17)	**Richard Howells**	The outline Matrix has been circulated. **Matrix scheduled for October 19th meeting. 19/10 Removed from agenda as not complete**
QPSC 1506/07	Assurance Process for Complex Care and CHC	An update be scheduled for a future Committee to report on the outcomes of the Brithdir reflection sessions with ABUHB, CCBC & CIW	**Secretariat**	A full outcomes report would be made available at a later date. ABUHB have undertaken further reflection internally –

				an update could be provided at September's meeting if required. **19.10.21** A meeting with partners has been arranged for November to progress actions required. The report will be shared once complete.
0109/11	**Medical Devices**	Peter Carr, agreed to circulate the detailed action plan with members.	**Peter Carr**	**19.10.21** Action Plan has been circulated to the Medical Devices Committee for ratification. Once approved this will be provided to PQSOC.
1910/06	**Dementia Companions and Meaningful Occupation mode**	Provide an update to members following the roll out of the coloured walking frame initiative planned for this week	**Rhiannon Jones**	
1910/07	**Infection Prevention & Control - update against 2021/2022 priorities**	A report to be received at the next committee meeting outlining progress against cleaning standards – pre and post implementation of the new standards. The paper to include the investment required and recruitment challenges	**Rhiannon Jones / Secretariat**	Added to FWP & agenda

1910/08	**Putting Things Right - update against 2021/2022 priorities**	Share the newsletter with Committee Members	Rhiannon Jones	
1910/13	**Annual Assurance Report on Health & Care Standards: Nutrition and Hydration**	Update the Equality Impact Assessment and recirculate the paper	**Peter Carr / Secretariat**	
		Determine why a different assessment tool is used in mental health and community settings	**Rhiannon Jones / Peter Carr**	
1910/17	**Highlight Reports: Urgent Care Transformation Board**	A report outlining the Urgent Care activity and improvements to be received at December's meeting	**Rhiannon Jones / Secretariat**	Added to agenda for information
		Share the Primary Care update regarding graduated care with Shelley Bosson	**Rhiannon Jones**	

Committee:	Patient Quality, Safety & Outcomes Committee
Date:	**8 December 2021**
Agenda Item:	**2.1**
Document Title:	**Urgent Care Improvement Plan**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality Safety and Outcomes Committee DATE Agenda Item:

Aneurin Bevan University Health Board

Patient Quality, Safety and Outcomes Committee

Urgent Care Improvement Plan

Summary

This paper provides a high level overview of the Urgent Care Plan for the Health Board which focuses on a summary of the key actions and initiatives that form the current Urgent Care Improvement Programme for the Health Board, led through the Urgent Care Transformation Programme Board (UCTB) particularly focussing on the next six months in the context of the current pressures and outlook for the upcoming winter to provide assurance to the Patient and Quality.

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Approve the Report	To provide assurance to the PQSOC in respect of the plan to secure improvements in urgency and emergency care
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	
Executive Sponsor: Leanne Watkins	
Author: Leanne Watkins, Director of Operations	
Report Received consideration and supported by:	

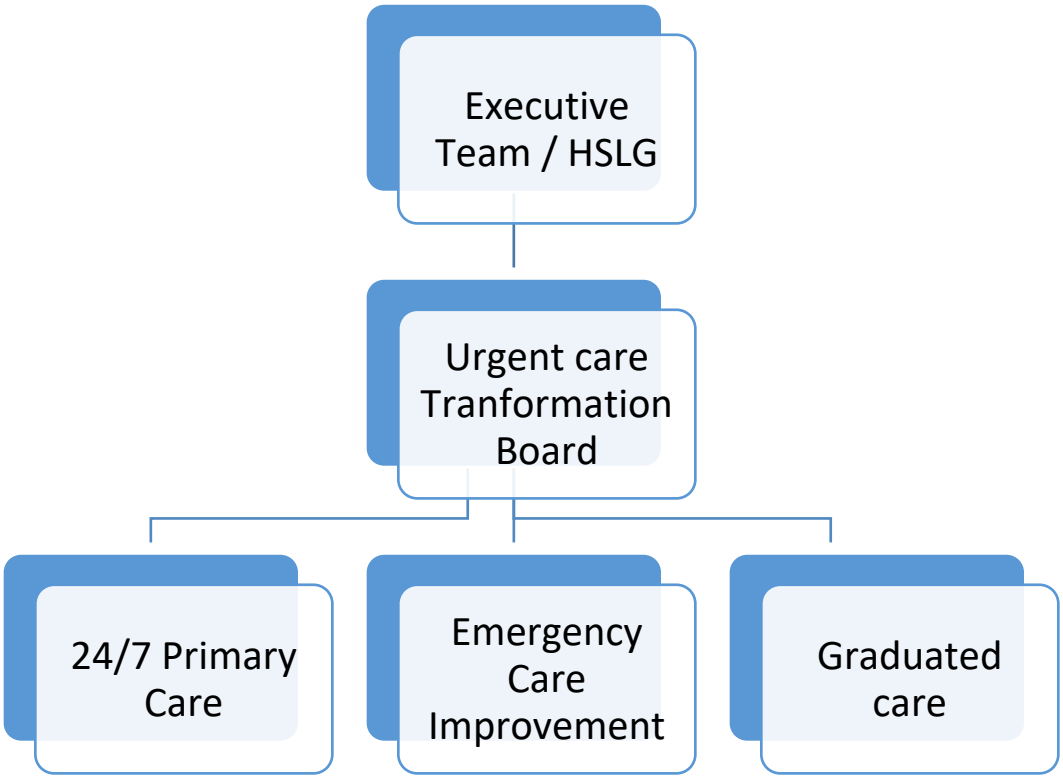
Executive Team		**Sub-Committee**	
Date of the Report: 8 December 2021			
Supplementary Papers Attached: N/A			

Purpose

This paper provides a high level overview of the Urgent Care Plan for the Health Board which focuses on a summary of the key actions and initiatives that form the current Urgent Care Improvement Programme for the Health Board, led through the Urgent Care Transformation Programme Board (UCTB) particularly focussing on the next six months in the context of the current pressures and outlook for the upcoming winter to provide assurance to the Patient Quality, Safety and Outcomes Committee. The programme key principles include:

- Whole system response to emergency and urgent care pressures;
- Managing demand and support patients to access services in the right place first time;
- Delivering Care Close to Home where safe and appropriate;
- 'Home is Best' ethos for patient transfers and care delivery;
- Support services to deliver care in the most effective and timely way.

The Urgent Care Transformation Board was established to provide leadership and oversight for a whole system approach to urgent care improvement and is being progressed through three workstreams as illustrated in the diagram below.



Current Work Programme

There is a significant amount of improvement work already underway across the Urgent Care system in the context of relentless current pressures exacerbated by the Covid environment, changing demand, workforce shortages and social care system pressures. The following table attempts to summarise the high impact priority actions across each of the three workstreams with a particular focus on the actions expected to impact over the next six weeks and the next six months.

	24/7 Primary Care (NW)	**Emergency Care Improvement (LW)**		**Graduated Care (NW)**
	Effective Pre-Hospital Model	**Improving Front Door Model**	**Improving Hospital Flow**	**Improving Discharge**
Short Term	▪ GP Stack review ▪ RRV Pilot ▪ Flow Centre Pathways / weekend Consultant cover pilot ▪ UPCC- increased utilisation ▪ Home first assess at front door ▪ Direct Admission Pathways	▪ ED triage cards piloting ED consultant triage ▪ Maintain 3 trolleys (BAU) ▪ Transfer Team re-established and expansion proposals implemented ▪ Clinical speciality in reach ▪ Integrated Front door	▪ 3 moves an hour out of 1st Floor - inc pre-emptive moves ▪ Ward process reviews- all sites / clear care plans ▪ Medical staffing cover ▪ Respiratory Ambulatory Model	▪ Assessment teams 1 per site- rapid needs assessment of all onward referred patients. ▪ Graduated Care- better utilisation of our community step ups. ▪ Care planning for the high risk adults – pilot project
Medium Term	▪ Think 111 ▪ High Risk Adult Cohort (Venn diagram) ▪ Review of Ambulance demand (via EASC) ▪ Care home conveyance	▪ Interim/part Establishment of SDEC model ▪ Medical optimisation-communication-discharge	▪ Discharge Lounge model at all sites to support discharge and step down	▪ Standardise and streamline effective communication systems within D2A
Long Term	▪ Long term plan for Flow centre	▪ SDEC Development ▪ E Triage		

Each of the actions listed above are described in more detail in the supporting appendices including key milestones, expected impact and current status. The level of granularity on these actions increases at the appropriate levels in the governance structures.

It is also important to note that this improvement plan does not include many of the business as usual operational level improvements that are ongoing across the teams.

It is also worth highlighting there is a comprehensive public communication plan around urgent care that is a key component of the winter plan alongside a comprehensive workforce plan that is not covered in this report.

The below table provides highlights from October and November for some of the key near and short term projects on-going within Urgent Care Transformation.

Work Scheme	October Update	November Update	Expected Impact
Flow Centre – Consultant/ GP Stack review	GP aligned to the Flow Centre triaging patients on the ambulance stack, redirecting patients to appropriate pathways and services following a request for an emergency response by contacting 999. In place since June, working one day a week 9am-5pm.	Frailty Pathway/ Caerphilly CRT approved by LMC, implemented 10th Nov. Medical Model going for Exec review 15th Nov.	Patients redirected to GP. Patients redirected to PRU. Patients redirected to MIU/MAU.
RRV Pilot	Pilot is in fourth week, continue to monitor data impact, linking with WAST. Test concept for four weeks, review results and implement as core business.	Positive impact noted during pilot, benefits to be summarised in paper for WAST SOT Review, then to be implemented as business as usual	Ambulances cancelled, patient able to use own transport or conveyed with friends/family. Patients conveyed using lower level resource, supported by card 35. Reduction in community waits.
Direct admission pathways	DAP has been introduced across Gwent and has seen 22 pts directly admitted. Work ongoing to increase profile particularly amongst GP colleagues and also to introduce transfer pathway in order those individuals who weren't referred to the DAP can be moved to CRT within 12 hours of attendance at ED/MIU. Interrogation of data to understand current behaviour patterns and establish support to refer differently	27 Patients directly admitted to community hospitals. LOS 7 days. Discussions to commence to introduce a ring fenced approach to rapid access beds.	Increase opportunity for individuals to be care for closer to home. Reduce attendances at ED/MIU. Increase time at home (reduce length of stay)

Work Scheme	October Update	November Update	Expected Impact
Care home conveyance	Multiagency group established, data source obtained and utilised. Meeting with care home providers to co-design approach 25/11. Highest reasons for calls/conveyance is falls/injury from fall – response will be co-ordinated	Meetings are proving to be productive and a reference group has been established including 11 home managers from across the sector. First workstream is to look at falls management and prevention	Reduce calls to WAST and subsequent conveyances by 10% in year one
High Risk Adult Cohort	Two pilots commencing simultaneously 1. BG 'only frail' – multiagency group building on existing compassionate communities framework to ensure that those individuals who have been in hospital in the last year have health review and plan in place. 2. Diabetic cohort – exploring how DES and GMS contract supports the agenda and implement in an agreed cohort.	Pilot in BG commences 18th Nov with formal launch and multiagency approach Caerphilly, Monmouthshire and Newport discussions are being held with a view to commencing in December	Increase days at home in this cohort
SDEC Development	Capital plan for the re-configuration of GUH Level 1 Agile area set to commence on 8 November 21 and be completed in June 2022. Awaiting confirmation of SDEC revenue funding from WAG to enable dedicated recruitment activity to commence to align with the delivery of the SDEC facility.	SDEC Building works commenced on 8th Nov as planned. Awaiting WG confirmation of recurrent funding. SBAR to be drafted to recruit key roles immediately. Division meeting 15th Nov to discuss session capacity viability to support a winter SDEC service	Delivery of timely care to medical and surgical patients that would benefit from SDEC
Integrated Front Door	Team working improved within MIU & UPC to support enhanced re-direction. Improved relationships with both the Acute Physicians and the UPC GPs especially as these are now more consistently located within NHH. Plans in place to support the DVT pathway through UPC and also scoping ongoing for same day radiology	Phased implementation of DVT pathway in process of agreement. Same day X-ray reporting is the next key area of focus from improvement to the service	Work is ongoing to continue to develop integrated working relationships to support the pathway being received to directed to the most appropriate and prudent pathways. Integration provides the opportunity to reduce pressures within GUH through ability to provide care closer to home
Clinical speciality in reach	Specialities to identify and pull patients from floor 1 rather than push model.	ED, Surgery and Acute Med commenced kick-off discussions, plans to pull in multiple specialities to improve team working and communications and further understand the process where ambulatory service in place.	Quicker speciality intervention

Work Scheme	October Update	November Update	Expected Impact
Maintain 3 Assessment Trolleys	Agreed that BAU to hold 3 trolleys, and are only to breach if agreed by Exec. Adherence to this has been challenging at peaks of front door pressure.	This will be monitored during the weekend of 20/21 Nov to understand the drivers of trolley breaches and process for escalation to be trialled	Quicker speciality intervention
Respiratory Ambulatory Model	Planned to begin end of October for cohort of patients appropriate for ambulatory care. Referral from flow centre.	Implemented in 18th Oct at RGH. Continue to communicate clear pathway to the flow centre, GUH etc.	Most appropriate care at the right place

'System Reset Weekend'

On the weekend of 20th and 21st November 2021 there was a multidisciplinary team led by key Operational Leadership groups that provided an additional layer of system support to test some of the above work areas and learn from operational challenges observed. The enhanced support and focus over the weekend will be reviewed and data analysed to ascertain what worked well and that should be considered for continued deployment.

The weekend was considered a success in terms of team engagement and in terms of system flow. Though it is noted that demand was lower than what has been experienced in recent weekends. There were a number of observations and key takeaways to consider implementing for sustained system support, highlights summarised below.

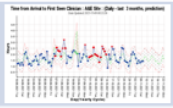
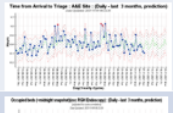
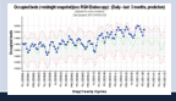
Area	Highlights
Flow Centre	Consultant cover was very beneficial - 8 ambulances cancelled. PRU support also helpful. A number of falls on this weekend.
Medicine	PA weekend cover reported to be valuable and supported reduced time to referral (Med) and earlier discharges.
CAHMS	Positive engagement between ED and CAMHS staff.
CEAU	Registrar cover all day and at front door reduced waits, improved flow and clear plans for those admitted.
Physio	Positive impact felt by the team with 11 front door referrals screened as potential discharges.
Pharmacy	Many discharge prescriptions processed could have been achieved on a weekday to speed up patient discharges.

In addition to the above work areas that sit within the Urgent Care Transformation Board, the below are additional improvements that form part of the winter plan submission. These provide an additional layer of needed provision to ensure sustainability of the urgent care programme through the winter period.

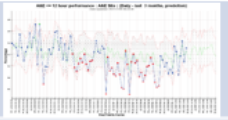
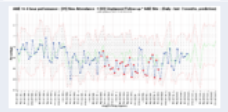
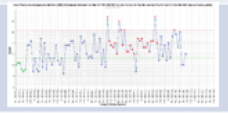
Scheme	Description	Impact
GP OOH & Expansion of UPC	▪ Support from additional winter 4x4 vehicle to support UPC business continuity and the wider Division ▪ Realignment of daytime Urgent Primary Care Nurse Practitioners to YYF base. ▪ Development of Nurse Practitioner mobile shifts, to undertake home visiting reviews within Nursing/Residential homes for minor illness in order to expand the multi-disciplinary team, freeing up GP capacity for more complex calls/base capacity. ▪ Advertisement of additional OCA (Overnight Clinical Assessor). ▪ Additional patient streams P1 to access UPC instead of own practice.	▪ Business continuity providing a Nurse. ▪ Practitioner led base at YYF, increasing the footprint and capacity to see Urgent Primary Care patients. ▪ Post to support the Clinical queue and shorter waiting times on a Friday and Saturday overnight. ▪ 40-50 patients per day.
Community hospital beds	▪ Open additional 20 beds Ruperra ward at St Woolos hospital and 16 beds on Tyleri Ward YAB. Additional 12 beds on Holly in January.	▪ Extra community/ step-down beds will support patient flow from GUH/eLGHs.
Commissioning Care Home beds	▪ The Health Board has recently engaged with nursing home providers to commission step down beds to facilitate early discharge from acute sites. It is anticipated the number can increase to 50 beds if required.	▪ Ability to discharge longer stay patients waiting for next stage of care.
Commissioning packages of care	▪ The Health Board has arranged to purchase POC from a private provider to alleviate the number of patients on acute sites waiting for a long term package of care.	▪ Ability to discharge longer stay patients waiting for next stage of care.
Rapid Response Team	▪ Advanced paramedic practitioner has been employed to temporary contract in Caerphilly, band 6 ANP employed on temporary contract in Blaenau Gwent and 2 Trainee band 6 employed in Newport and Monmouthshire.	▪ Increase to RRT allowing patients to remain at home with treatment and avoid hospital admission.
Reablement capacity	▪ Recruitment of additional 25 band 3 reablement support workers 5 per borough.	▪ Reablement Support Workers to increase Reablement Care capacity within Gwent, thereby releasing hospital bed capacity through greater admission avoidance and through facilitating quicker discharge home.

Improvement Metrics – Current Status

The below metrics represent the full measures to be used going forward as a measure of improvement for the Urgent Care Transformation Board (UCTB). The metrics will be monitored daily through a more robust operational review using the SFN tool and reviewed monthly at this high level. Monthly snapshots will be referred to and monitored closely as we follow the trajectory through the winter period and beyond.

Key Metric	Target	Sept 21	Oct 21	Signal	Signal explanation/Comment	Chart/Graph
Time to be seen by first clinician never above 2 hours	↓ 95%	13 events	9 events	No Signal		
Time for bed available from request - 8 hours	↓ 95%	27 events	29 events		Sustained increasing trend	
No more than 70 Ambulance hours lost in a day (daily average)	↓ 95%	69.5 hours	72.6 hours	No signal	Increasing trend	
ED Triage Time	↓ 0.25 hours	0.66 hours	0.64 hours		Out of range twice during October	
Occupied Beds monthly av	↓	1403	1468		Sustained increasing trend. Upper range.	

Key Metric	Target	Sept 21	Oct 21	Signal	Signal explanation/ Comment	Chart/Graph
ED Attendances (all sites/month avg)	↓	537	501	No Signal	Currently decreasing trend	
UPCC contact (monthly)	↑	7284	5004		Out of usual range w/c 4th October	
Redirections from GUH (Count of both in and out-of-hours)	↓	188	163	No Signal	Currently decreasing trend	
Redirections of MIU (Count of both in and out-of-hours)	↓	613	528		Continued decreasing trend	
Think 111 calls (Count of both in and out-of-hours)	↑	445	309		Continued decreasing trend	

Key Metric	Target	Sept 21	Oct 21	Signal	Signal explanation/ Comment	Chart/Graph
111 calls abandoned	↓	30% range 15-47%	TBC	TBC	TBC	TBC
Ambulance Handovers >1 hour	↓	931 events	1005 events	No Signal	38.3% of Ambulance handovers >1hour during October	
<12 hours %	↑ 100%	91.7%	89.1%		Highly variable and out of range 10 times during October	
<4 hour %	↑ 100%	63.9%	61.8%		Decreasing trend lower range	
Waits in ED over 16 hours	↓ 0	499 events	593 events		Increasing trend	

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Key Metric	Target	Sept 21	Oct 21	Signal	Signal explanation/ Comment	Chart/Graph
LOS over 21 days	↓	531	544		Continue to increase out of range since start of Sept and not following predicted seasonal trend	
DTOCs – Secondary Care monthly average	↓	69.9	59.4		Decrease in Secondary care DTOCs	N/A
DTOCs – Community monthly average	↓	103.8	87		Decrease in Community DTOCs	N/A
Ave Daily discharges	↑	376.9	353.4	No Signal	Within range	

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Impact of Priority Actions

It is very difficult to quantify the exact impact of individual actions on the variety of metrics we use to measure the urgent care system in terms of patient quality, safety, experience and efficiency. However, the combination of the above actions are expected to impact on a number of key metrics listed below that will in effect impact on the key Q&S measures:

Pre-Hospital Demand	Front Door	Hospital Flow	Discharge
• ED attendances • redirections • UPCC • 111 calls • 111 abandoned calls	• Ambulance lost hours • 4 Hours • 12 hours • Triage time • ED WTBS	• Beds occupied • LOS	• DTOCs • Daily discharges • CRT interventions

Governance and Reporting Arrangements

This programme of work is led by the UCTB reporting up to Health System Leadership Group and Executive Team and is one of the 10 priority programmes identified in the Annual Plan 2021/22 supported by the Clinical Futures Programme Team. Work is underway to strengthen the actions and outcomes of the projects and workstreams under the UCTB in terms of targeted action and improvement trajectories.

Communications

Continued public messaging including social media to ask the public to consider other options before attending the Emergency Department.

AB UHB Bus Tour continues to engage public with signposting messaging on how to access urgent care.

Conclusion
In summary this report provides a high level overview of the actions that make up the Health Board's Urgent Care Improvement Programme primarily focusing on the next six months and should be considered in the context of the broader Health Board Winter Plan when it is finalised in the next few weeks. A clear governance and reporting structure has been agreed and will be implemented with immediate effect to strengthen executive team oversight, accountability and risk management. An improvement trajectory has been developed that will require close monitoring alongside daily operational performance management. Clinical Futures Programme Management support will be realigned to ensure broader support to the UCTB and supporting structures. This is as part of a 'reset' to the Clinical Futures team to meet the 10 major change priority agenda agreed by the organisation. Further work will be undertaken to consider long term (beyond 6 months) strategic changes to the Urgent Care system.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report provides a high level overview of the Urgent Care Plan for the Health Board which focuses on a summary of the key actions and initiatives that form the current Urgent Care Improvement Programme for the Health Board, led through the Urgent Care Transformation Programme Board (UCTB) particularly focussing on the next six months in the context of the current pressures and outlook for the upcoming winter to provide assurance to the Patient and Quality. Issues are part of Corporate Risk Register and Divisional Risk register.
Financial Assessment, including Value for Money	Some issues highlighted within the report will require additional resources to support further improvement. In many cases, improving the quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.

Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	As an assurance report, this paper does not require an impact assessment.
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care, timely and dignified care.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement – Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	NA
Public Interest	Report has been written for the public domain.

External Inspections:
HIW, CHC
Wales Neonatal Network
Peer review Report

Document Title:	**External Inspections: Healthcare Inspectorate Wales & the Aneurin Bevan CHC**
Date of Document:	**25 November 2021**
Executive Sponsor:	Rhiannon Jones, Executive Director of Nursing

Summary / Situation:

This report provides a summary of HIW and CHC inspection and Wales Neonatal Network Peer Review Report across the Health Board and includes:

- The HIW unannounced visit to Mental Health wards in St Cadoc's Hospital;
- The HIW unannounced visit to the Emergency Department and Assessment Units in the Grange University Hospital;
- The HIW national review of patient experience whilst waiting in ambulances during delayed handover;
- The Community Health Council Report: 7-days in Emergency Department at GUH;
- Wales Neonatal Network Peer Review Report.

Background:

The Health Board has been subject to two unannounced inspections by HIW as well as being part of the national review of patient experience whilst waiting in ambulances during delayed handover together with a 7-day visit to the Emergency Department at GUH by the CHC and a peer review from Wales Neonatal network

Assessment

HIW WAST/Health Board review

In April and May 2021, HIW conducted a national joint Welsh Ambulance Service NHS Trust (WAST) and Health Board review of patient experience whilst waiting in ambulances during delayed handover. Their final report has been published and Aneurin Bevan University Health Board have provided a response to the report. There were 12 national recommendations, of which all are applicable. However, there are three areas that are ongoing for the Health Board:

1) Patient flow issues impacting on delayed patient handover.

2) Appropriate representation is present at WAST Serious Clinical Incident Forum meetings.

3) A consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.

The response can be found in (**Appendix 1).**

CHC 7 days in the Emergency Department

During August 2021, a small number of CHC members attended the Emergency Department, GUH to undertake a patient survey over a 7-day period from 16th-22nd August 2021. During visits CHC members undertook general observations of the ED, which culminated in a formal report. There were five observations:

1) Physical capacity in the ED unit;

2) Staff well-being;

3) Whole system pressures in Health and Care services;

4) Patients' needs being met whilst experiencing long wait;

5) Waiting times.

The Health Board received some media attention as a result of the report. An action plan has been produced and published by the CHC which addresses all their recommendations **(Appendix 2)**.

HIW unannounced visit to St Cadoc's Hospital

On the 13th September 2021 HIW undertook an unannounced inspection to the Mental Health Wards in St Cadoc's Hospital. The Health Board received three Immediate Assurances, as indicated below:

1) The segregation of patients in the psychiatric intensive care unit

2) The development of a more robust Wound Care Plan for a patient

3) Development of a Divisional Policy for Long Term Segregation

A response has been provided regarding the above, with HIW confirming they are assured. 1 & 2 have been addressed. Number 3 has a completion date of December 2021.

The Health Board has recently received the final report following their visit and the Health Board has responded. HIW have confirmed there is sufficient assurance from our response. The Health Board is due to provide an update on all actions by the 13th December 2021 (which is three months on from the initial visit).

HIW unannounced visit to GUH

On 1st November 2021, the Health Board had a further unannounced visit to the GUH Emergency Department and Assessment Units. There were four Immediate Assurances area result, as below:

1) Improved visibility of patients in the ED waiting area;

2) Improved infection prevention and control measures in the Covid corridor;

3) Regular and systematic checking of resuscitation trolleys;

4) Workforce experience.

The Health Board have provided a response regarding the immediate assurance to which HIW have confirmed they are satisfied with our actions. The final report is awaited.

In terms of the HIW WAST/Health Board national review and the CHC 7 day review the Health Board has amalgamated the recommendations to have one overarching report. The actions are being overseen by the Urgent Care Transformation Board.

Wales Neonatal Network Peer Review Report

On 29th April 2021 the Grange University Hospital (GUH) was peer reviewed as part of the Wales Neonatal Programme. The Division submitted comprehensive self-assessment documentation supported by evidence across the following themes:

- Patient Centeredness and Care of Baby/Family
- Safe & Effective Care
- Equitable & Efficient care
- Timeliness

The panel felt that there were areas of good practice and significant achievements which include :

1) Location and layout of quiet room
2) Pods in Special Care, excellent facilities
3) Golden Drops project
4) Staff retention, good despite move
5) QIS standards maintained
6) Parent cot side Facilities
7) Annual report
8) Workforce plans

The panel felt also that there were areas of concerns which encompassed :

1) Visiting
2) Entrance to unit
3) Golden Drops project
4) Confidentiality
5) Benchmarking

The Health Board have provided a response and produced an action plan addressing areas of concern. The report and action plan will be published on the Wales Maternity & Neonatal Network website **(Appendix 3)**.

Recommendation:

The Patient Quality, Safety and Outcomes Committee is asked to:

- **Discuss** the report and **note** the Health Board actions.

ABUHB Management Response: HIW Review of Patient Experience whilst waiting in Ambulances during Delayed Handover

Recommendation
Health boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.

Response	Lead Officer
Aneurin Bevan University Health Board have established an Urgent and Emergency Care Transformation Board which is Executive-led with multi-agency membership. There is a clear improvement plan which is whole system and focussing on pre-hospital streaming, management at the front door, discharge to recover and assess and reducing length of hospital stay/time away from home. The Executive Team are have submitted a bid to Welsh Government for Same Day Emergency Care (SDEC), together with opportunities to potentially increase the Emergency Department footprint in GUH. The Health Board is working collaboratively with Local Authorities to develop an effective and innovative Winter Plan to improve quality, safety and patient experience. (Additional information can been seen in Appendix 1).	Executive Director of Primary, Community and Mental Health

Recommendation
Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.

Response	Lead Officer
The Health Board has a HALO in place, 10:00am to 10:00pm to support the handover process. Co-ordination will be given to whether the operating hours of the HALO can be increased. There is also a Divisional leadership point of contact for escalation and resolution of long waits. (Additional information can be seen in Appendix 2).	Director of Operations

Recommendation
Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.

Response	Lead Officer
The Health Board has a good relationship with WAST from a quality and safety perspective and work collaboratively to address serious clinical incidents. Representatives from ABUHB are always present at Clinical Incident Forum Meetings but this tends to be the Head of PTR and Assistant Director of Nursing for Quality & Safety. We need to strengthen engagement from the operational team, this will be enabled following the appointment of a General Manager – Operations.	General Manager - Operations

Recommendation
If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.

Response	Lead Officer
A draft Ambulance Handover Standard Operating Procedure has been developed and the Health Board will engage with WAST for comments, joint sign-off and implementation.	General Manager – Urgent Care

Recommendation	
WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.	
Response and Action	**Lead Officer**
The Triage Nurse, Nurse-in-Charge and the HALO work cohesively to ensure effective communication regarding plans for handover and take responsibility for ensuring that patients and their relatives are kept up-to-date. This process can be compromised as the HALO is not a 7/7 service and when the department is overcrowded, impacting on effectiveness.	Senior Nurse, ED

Recommendation	
WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.	
Response	**Lead Officer**
Real-time patient feedback is important and we have a number of mechanisms to secure patent views of services, to include patients who are held on ambulances for an extended period. We have worked collaboratively with the Community Health Council to facilitate an independent review of patient experience and the CHC have recently conducted a review interviewing circa 80 patients. The reports are discussed at Directorate, Division and Executive level. (Additional information can be seen in Appendix 3).	Divisional Nurse, Unscheduled Care

Recommendation
WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.

Response	Lead Officer
Patients are registered on arrival to the ED using a dedicated IT system (Symphony) which identifies patients, their location and clinical presentation. There is a dedicated ED ambulance triage nurse 24/7 who conducts Patient Triage within the department or on the ambulance if there is an inability to conduct timely off-load. Ongoing monitoring and escalation of patients is the joint responsibility of the WAST/ED team prior to handover. Provision of the Fundamentals of Care and ongoing treatment prior to handover is jointly managed by WAST and ED staff. Patients will undergo clinical assessment on the ambulance by clinical teams and appropriate investigations are undertaken (bloods, x-ray, CT).	Clinical Director - ED

Recommendation
Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.

Response	Lead Officer
The Nurse-in-Charge/HALO work collaboratively to ensure the dignified care of people who are waiting on an ambulance. A Toileting Procedure has been introduced (Appendix 4).	Senior Nurse, ED

Recommendation
During prolonged handover delays, WAST and health boards must work collaboratively and consistently to minimise the risk of skin tissue damage for patients.

Response	Lead Officer
Patients are risk assessed for pressure damage as part of the triage process. Where a patient is deemed to have an elevated risk, the patient is prioritised for a trolley to support appropriate pressure relief at the earliest opportunity. The Health Board has purchased additional pressure relieving equipment for patients who are waiting on an ambulance.	Senior Nurse, ED

Recommendation	
WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.	
Response	**Lead Officer**
The Health Board introduced a system for the provision of nutrition and hydration for patients who are in an ambulance awaiting off-load.	Senior Nurse, ED

Recommendation	
WAST and Health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.	
Response	**Lead Officer**
The Health Board acknowledges its responsibility for the health needs of the population of Gwent. A shared care arrangement for patients that are delayed on an ambulance is in place, which outlines expectations and responsibilities (this is cognisant of the RCEM position. (For additional information see Appendix 5).	Director of Operations

Recommendation	
WAST and Health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	
Response	**Lead Officer**
The Health Board takes all reasonable steps to ensure appropriate staffing to care for patients. There is full awareness of its duty associated with the Nurse Staffing Levels (Wales) Act to have due regard for the provision of sufficient nurses to allow time to care for patients sensitively wherever they are receiving a nursing service (Section 25A). A review of clinical staffing has been undertaken as a result of the early opening of GUH and the increased demand that has been seen across urgent and emergency care.	Director of Operations

APPENDICES		
Appendix 1	**Emergency Department Work Programme**	Front door sprint diagnostic summary ED work programme.xlsx
Appendix 2	**Executive Team: Patient Safety Ambulance Handover**	Executive Team SBAR Ambulance Ha
Appendix 3	**Patient Experience and Audit**	ED Specific 1 Pt 1 Day Audit June 2021 Patient Experience Survey Feedbac1.do
Appendix 4	**Toileting Policy**	Ambulance toileting SOP.docx
Appendix 5	**Royal College of Emergency Medicine - Ambulance Handover Delays: Options Appraisal to Support Good Decision Making**	RCEM_College_Paramedics_Joint Statem

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

CHC Engagement Exercise
Emergency Department, Grange University Hospital
ABUHB response to the recommendations (October 2021)

CHC Recommendation		Response	Responsibility	Timescale
1)	The CHC would be pleased if the highly positive comments made by people regarding the care and approach from the staff could be shared with the department teams. It was evident from the feedback that people appreciated the hard work and efforts of staff during a visibly difficult time.	• It is positive to note the feedback from the public & staff within the ED, who are working incredibly hard, will appreciate the comments. • The CHC Engagement Report has been shared with the ED Directorate Leadership and Management Team for cascade.	Director of Nursing	Completed
2)	The CHC is concerned about the feedback regarding the physical capacity of the Emergency Department unit, including the waiting area, following the reports of people observed sitting on the floor and waiting for long periods outside in ambulances. The Health Board is asked to respond to the observations and share plans being considered to address the capacity issues and waiting time concerns.	• ABUHB have reported the substantial increase in demand at the ED, GUH which has been beyond predictions. This, coupled with the challenges of patient flow & Covid pathways, has resulted in long waiting times in ED and, on occasion, over-crowding. • There is work in-train to increase the footprint of the waiting area with a short term solution and a longer term option being worked through. These plans will be shared with the CHC.	Director of Planning	October 2021

CHC Recommendation		Response	Responsibility	Timescale
3)	The Health Board is asked to consider the feedback about communication. People told us that information about waiting times and waits for treatment would be helpful.	• We appreciate this feedback and agree that effective communication about waiting times is important to manage people's expectations and minimise anxiety. • Work has already been triggered to introduce an electronic waiting time 'board' within the ED Waiting Area. • An update on progress will be provided to the CHC.	Director of Planning	October 2021
4)	The Health Board is asked to respond to feedback from staff about the increased demand and reported impact on staff wellbeing from working in a high pressured environment.	• The Clinical Director for ED and the Divisional Director for Urgent Care have escalated the concerns about capacity and demand, over-crowding in the Department, the impact on treatment times and the experience for patients and staff. • The issues are being addressed through the Urgent Care Transformation Board, with a number of work streams focussed on admission avoidance, patient streaming, patient flow and Length of Stay. The work streams are data-driven and evidence-based. • Additional well-being support has been secured for ED staff and well-being sessions have been organised, together with regular de-brief meetings. • Medical and Nursing staffing reviews have been conducted and the Executive Team have approved an increase in resource, with recruitment of additional staff in-train.	Director of Primary Care, Community & Mental Health as the Chair of the Urgent Care Transformation Board	Monthly UCTB meetings

CHC Recommendation		Response	Responsibility	Timescale
5)	The CHC would like to understand if refreshments are provided to people in the initial wait area in view of the length of waits reported.	• A review of nutrition and hydration has been completed to increase provision for ED in light of waiting times. Refreshments are provided for people in the waiting area.	N/A	N/A
6)	The CHC recognises the whole-system pressures in Health and Care services, which are affecting people's care, experience and the NHS' ability to deliver timely care. In view of these concerns the Health Board is asked to share plans and developments being introduced or planned with Social Care colleagues and other partner organisations to address the pressures.	• There is active multi-agency work to finalise the Winter Plan which will outline the actions being taken, whole system, to manage pressures, improve flow and patient experience. • The Winter Plan will be shared with the CHC.	Director of Primary Care, Community & Mental Health	October 2021
7)	The CHC would like to understand how the Health Board will address the feedback in relation to people's comfort levels and pain management when experiencing long waits.	• Regular Dignity and Essential Care Audits are undertaken by the Senior Nurses for ED. These audits review fundamentals of care. The most recent audit was undertaken at the end of September and showed that essential care was being provided for patients whether delayed in an ambulance, in the waiting area or experiencing delays in the Majors. • In light of the feedback the Senior Nursing Team will ensure on-going auditing and patient satisfaction surveys to assess people's experiences and ensure action to address deficits, with the Nurse-in Charge ensuring a focus on comfort and pain.	Senior Nurse, ED	Further Auditing in October 2021

Aneurin Bevan University Health Board

Neonatal Unit, The Grange University Hospital

Peer Review 29 April 2021

Serious Concerns Action Plan @ October 2021

Theme	Title	Detail of Risk	Rationale	Actions	By when	Responsible person
Safe & Effective Care	CLABSI (*central line associated blood stream infection*) rate	High levels of sepsis were identified by Unit staff. They have started some quality improvement. Vital that the level of CLABSI reduce.	Levels are above NNAP and VON average (2019 report)	• Infection control team established, with input from IPAC team. • Re-launch of central line care bundle. • Root cause analysis of positive culture cases • Analysis of the pathway for central lines, from criteria for insertion, length of time line can stay in, care of the line, aseptic techniques for insertion. • 'Two to care' approach (observer for sterile procedures). • Review of equipment e.g. new central line trolleys, sterile packs.	In place. Aim for reduced rates for 2021 report. There is evidence from the 2020 VON report that CLABSI rates are already declining with the ongoing measures.	NICU infection control team, Lead NICU consultant & lead NICU nurse

Equitable & Efficient Care	Workforce	There is a major deficit in provision of Allied Health Professionals	Multi-professional support to babies is essential to improving both short and long term outcomes. Contributions made by Allied Health Professionals can not only optimise outcomes for high risk infants, but can reduce the length of time a baby needs to stay in a unit.	Multi-Disciplinary Team (AHP) workforce paper to support business case in draft. The gold standard is to aim for levels of Allied Health Professionals (including Physiotherapy, Occupational Therapy, Speech and Language Therapy, Dietetics and Psychology) as per the BAPM recommendations. Business case for increased pharmacy support to NICU to be developed.	Dec 2021 Commence business case development November 2021	Head of Speech and Language Therapy, & Neonatal therapy leads Family & Therapies Divisional Pharmacist/ Divisional Partnership and Transformation Manager
Equitable & Efficient Care	High level of Special Care activity	A high level of Special Care activity was noted, continuously above the	The All Wales Neonatal Standards 3rd Edition state that average cot	Centralisation of SCBU cots from NHH and RGH sites to GUH occurred from November 2020 and has reduced the cot occupancy by	Completed	

		recommended 80%, at its highest the Unit was close to 300% occupancy. However it should be noted this was for activity in Royal Gwent and since relocation of the neonatal units The Grange has more closely maintained recommended special care levels.	occupancy will not exceed 70% for critical care and 80% for special care.	improving efficiency of staffing and cot usage.		
Patient Centeredness and Care of Baby/Family	Reducing Term Admissions and Mother –baby separation	There is a lack of a properly funded Transitional Care (TC) facility meaning only four TC babies are able to be cared for on the postnatal wards. A lack of TC does mean that some babies are unnecessarily separated from their mother.	The British Association of Perinatal Medicine (BAPM) A Framework of Neonatal Transitional Care highlights that *"Implementation of NTC has the potential to prevent thousands of*	1. Introduction of robust protocols for managing infants on the postnatal wards, such as hypoglycaemia policy and Atain project to reduce term admissions with respiratory problems or hypoglycaemia. 2. Improve transitional care facilities. This was agreed in principle prior to the move to GUH. However, the increased postnatal bed	12- 18 months End 2021/22 Modelling support from Lightfoot analysts invited	NICU guideline development team NICU Management Team

		A properly funded TC service was agreed for the move to GUH but has not yet been possible due to lack of funding and space on the postnatal area.	*admissions annually to UK neonatal units, and also to provide additional support for small and/or late preterm babies and their families"* National Neonatal Audit Programme (NNAP) measures - Minimising inappropriate separation of mother and term baby and mother and late preterm baby.	occupancy in GUH has added pressure to the development of a dedicated transitional care ward in the postnatal area, due to lack of space. 3. Discharging infants home with some NG tube feeding supported by the Neonatal Outreach Team will enable earlier discharge from NICU. 4. Finalise Mitchell Close parent accommodation to allow parents of babies in NICU to stay on the hospital site	November 2021. Revisit TC business case 2022 Conclude Scoping the discharge potential by end January 2022, and move to business case development in 2022/23 for additional investment in Outreach Nursing Before end March 2022	Neonatal Liaison Nursing Lead Business Case lead to be identified before end 2021/22 Service Manager – Paediatrics & Neonates

Patient Centeredness and Care of Baby/Family	Training & Education	Lack of up to date training for post mortem counselling	The All Wales Neonatal Standards state *Each unit will have in place a protocol for post mortem consent*	Training has now been accessed successfully and will continue to be provided by trained midwives. A neonatal consultant is on the waiting list for a train the trainers course	In place 12 months	Trained Midwife Neonatal Consultant

Concerns Action Plan @ October 2021

Theme	Title	Detail of Risk	Rationale	Actions	By when	Responsible person
Safe & Effective Care	Benchmarking	Lack of action plan for NNAP measures	Unit should display their response to NNAP public reports for parents and staff to understand the improvements being made.	Information boards are now in place and have been populated with the quality improvement projects that are on-going on the NICU, including those in response to NNAP reports	In place	NICU quality improvement team
Patient Centeredness and Care of Baby/Family	Confidential data	Dashboard submitted to Peer Review Panel included PII information, Unit staff recognised this had been	Maintain patient confidentiality at all times in line with policy.	Extra vigour required when submitting examples of data to any panel or source. Review of Share point information currently stored	Immediate 12 months	NICU Lead Nurse and Lead Consultant

		overlooked. Panel Chair requested staff to re-examine the requirement for PII within a dashboard at unit level.				
Patient Centeredness and Care of Baby/Family	Visiting	Exclusions of Grandparents (etc.) after 7pm	Ethos of family integrated care	For review as community infection rates decline, allowing return to normal policies where extended family can visit the NICU.	12 months.	NICU Nurse in Charge
Patient Centeredness and Care of Baby/Family	Visiting	Single parent Access (not both parents). Recognised risk of pandemic and WG visiting guidance	Parents are not visitors and should not be considered as such. Highlighted by Network and escalated to Welsh Government	This was already updating at the time of the Peer Review, to allow both parents to be present together at the cot side. There is a limit to total numbers of parents in one nursery at any one time (6 in a 6 bedded ITU/HDU nursery), meaning parents may need to coordinate visits. This will be reviewed as per WG advice, as community rates of infection reduce.	6 - 12 months	NICU Nurse in Charge
Patient Centeredness and Care of Baby/Family	Entrance to the Neonatal Unit	There is no call bell at the second entrance door. Raised by both unit staff and parents as an area that	Parents would be left waiting for a staff member to allow access	Door now inactivated	Resolved	NICU Nurse in Charge

		requires improvement				
	Consent policy	Consent policy not in place	Discussion ongoing with National Parent Advisory to consider how best to address this and Health Board colleagues are encouraged to support the Network in this work	Health representatives at Network Steering group will support this work. Await finalised BAPM document.	12 months	Neonatal Network Working Group

S Papworth/C Satherley/ A Williams
October 2021

Committee:	**Patient Quality, Safety & Outcomes Committee**
Date:	**21/12/2021**
Agenda Item:	**2.4**
Document Title:	**Learning From Death**

Aneurin Bevan University Health Board

Patient Quality, Safety and Outcomes Committee

Learning From Death

Summary

The first learning From Death Paper report has identified a number of themes

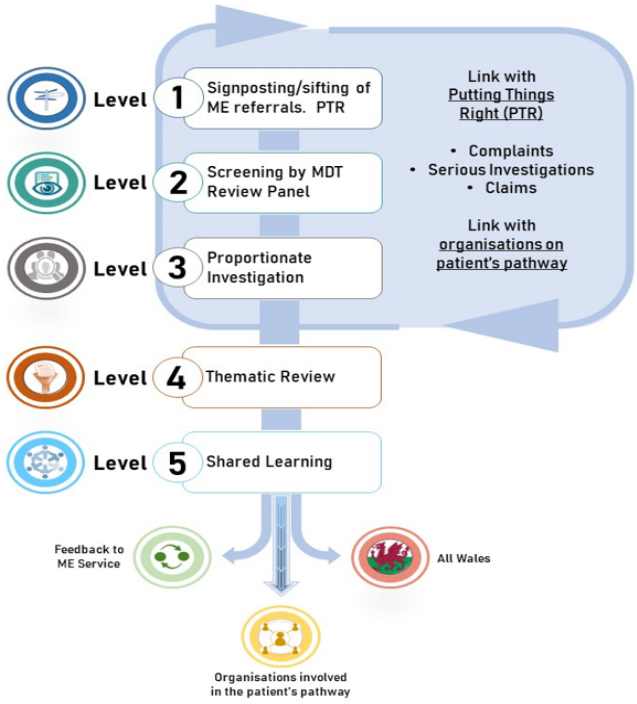
- **ABUHB Risk adjusted Mortality Index (RAMI) is in line with Welsh RAMI**
- **Increases in death above the 5 year average were noted in April 2020 and between October 2020 and January 2021 associated with Covid**
- **Just under 25% of cases reviewed by the Medical Examiner are referred back to the Health Board for further consideration**
- **The most commonly occurring words in the cause of death in cases referred to the Health Board by the Medical Examiner were pneumonitis, pneumonia, Covid and pleural.**
- **The most common concerns raised by the Medical Examiner were communication, Covid and family concerns**
- **A thematic review has been undertake relating to deaths occurring within 48 hours of intersite transfer**
- **Robust process are in place to review hospital acquired thrombosis**
- **The majority of MI related deaths are Non ST elevation MI deaths.**

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Discuss and Provide Views	x
Receive the Report for Assurance/Compliance	x
Note the Report for Information Only	
Executive Sponsor: Dr James Calvert Medical Director	
Author(s): Alexandra Scott – Assistant Director of Quality and Patient Safety	
Report Received consideration and supported by:	

Executive Team		**Sub-Committee**	
Date of the Report: 8th December 2021			
Supplementary Papers Attached: Nil			

Situation
Since July 2021 the Health Board has convened a Mortality Review Screening Panel to review and further investigate referrals made by the Medical Examiner. The emerging themes have been combined with information from clinical coded data, and national audits to support learning from death and will be reported to the PQSO Committee in a bi-annual paper.
Background and Context
Health Organisations across Wales use a number of measures to consider mortality. The Risk Adjusted Mortality Index (RAMI) adjusts for individual patient risk factors and co morbidities and therefore allows comparison between organisations. The accuracy of RAMI is dependent on the completion and accuracy of clinical coding, (January 2021 – August 2021 10.47% of ABUHB finished consultant episodes were uncoded). In 2014 Professor Palmer published an independent review of the use of RAMI and the extent to which it provides valid data and recommended a blended approach that considers numerous sources on information in addition to RAMI, including that from mortality reviews and national audit. There will be a statutory requirement for an independent review of all deaths in Wales by a Medical Examiner (ME) service by summer 2022. There has been a phased approach across ABUHB to implement this system since November 2020 with inpatient deaths in YYF, GUH and RGH now subject to independent scrutiny by the ME. The National Mortality Framework illustrated in figure 1, describes 5 levels of mortality management **Figure 1**

5.5 Mortality Review 5 Levels of management



Prior to the implementation of the ME service, Health Boards in Wales were required to undertake universal mortality reviews of inpatient deaths. The review included consideration of any adverse incidents including injuries or accidents that occurred during the inpatient spell including falls, the development of pressure ulcers, unplanned return to theatre, unplanned admission to ITU, hospital acquired infection including pneumonia and Clostridium difficile (C diff), adverse drug reactions and delays in treatment and diagnosis. Where adverse incidents were noted, a second and more detail review was requested by the clinical team.

The themes addressed throughout the paper have been extrapolated through mixed sources including data derived through clinical coded activity, national audit, ABUHB universal mortality reviews and ME reviews.

Assessment and Conclusion

RAMI

Figure 2 illustrates the ABUHB RAMI compared to Welsh peers until October 2021 and demonstrates a comparable mortality rate. Figure 3 includes additional information relating to deaths where covid was included on the death certificate, whether as an underlying cause or not. The increase in deaths above the 5 year

average in Gwent and across Wales noted in March / April 2020 and November to January 2021 correlate with the deaths associated with Covid.

Figure 2

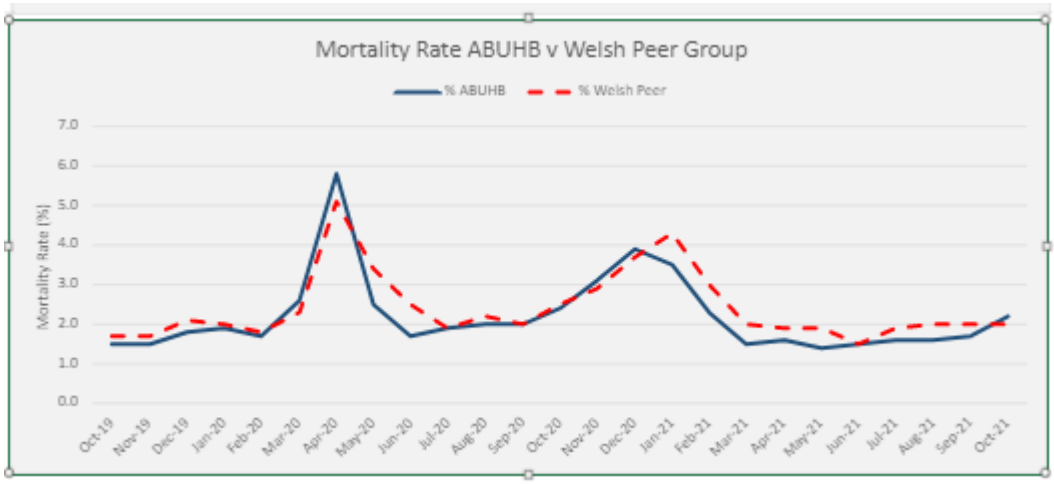
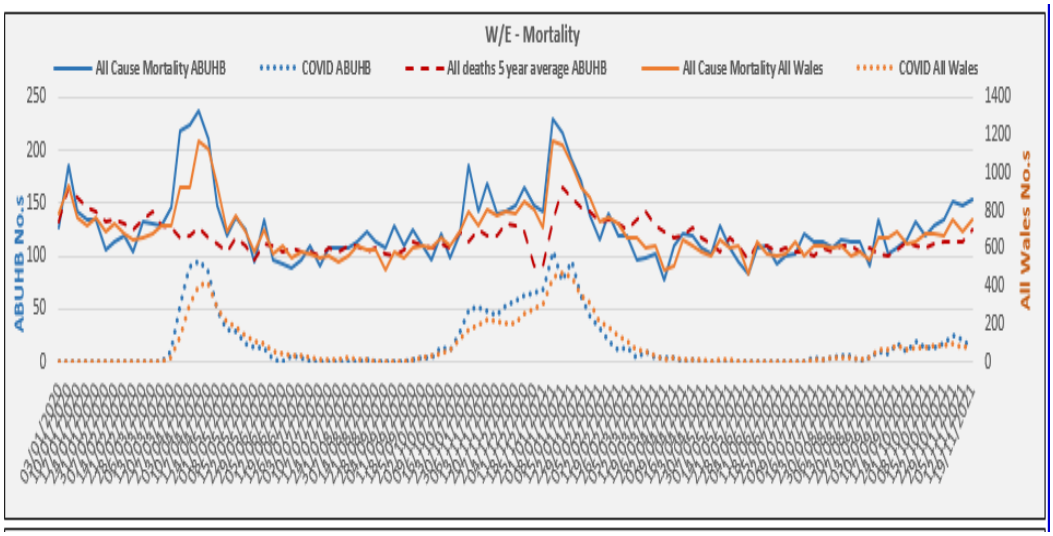


Figure 3



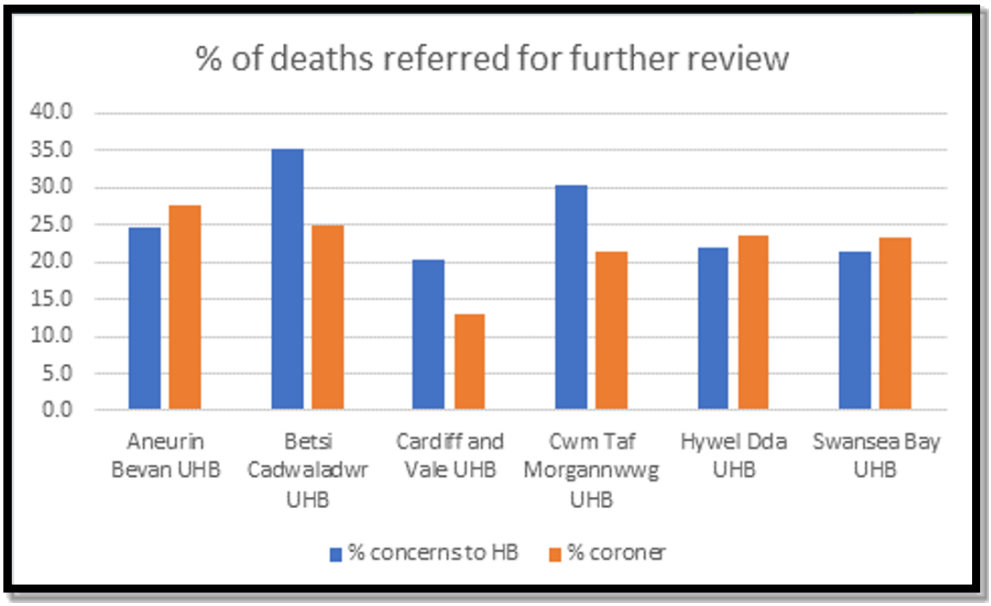
Medical Examiner

All mortality cases referred back to the Health Board by the ME are subject to an initial review (level 1) to establish if they are already being investigated through an established process including Putting Things Right, to avoid duplication.

All referrals subject to a Level 2 mortality review are considered by a multidisciplinary panel with cross divisional representation. The panel establishes if further investigation is required and sets out the terms of reference for the investigation and agrees who should be commissioned to undertake this. These further reviews can include specific questions being asked at a mortality and morbidity meeting, referral for investigation under PTR process, consideration at the ABUHB Falls Review Panel, Infection prevention and Control review and hospital acquired thrombosis review.

Figure 4 illustrates that just over 25% of cases reviewed by the ME services are referred back to the Health Board to consider further review and investigation, and that approximately 27% of cases that have been reviewed by the ME service were subsequently referred to HM Coroner. There is some variation in the proportion of reviews that are forwarded for level 2 reviews between health boards in Wales, however there is significant variation in the numbers of cases being reviewed in each Health Board, with some organisations having relatively small numbers of cases reviewed at present.

Figure 4



The ABUHB Mortality Referral Screening Panel commenced in July 2021 and has considered 229 referrals since commencement. Figure 5 illustrates a thematic review of the agreed cause of death recorded in referrals back to the Health Board. Pneumonia, Pneumonitis, Covid and Pulmonary are the most commonly recurring causes of death with Covid emerging as a dominant theme throughout these referrals.

Figure 5

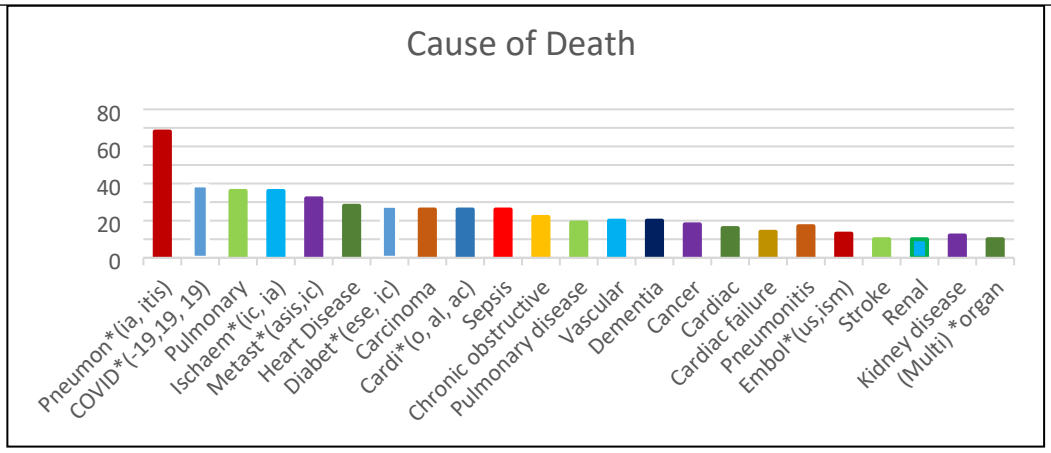
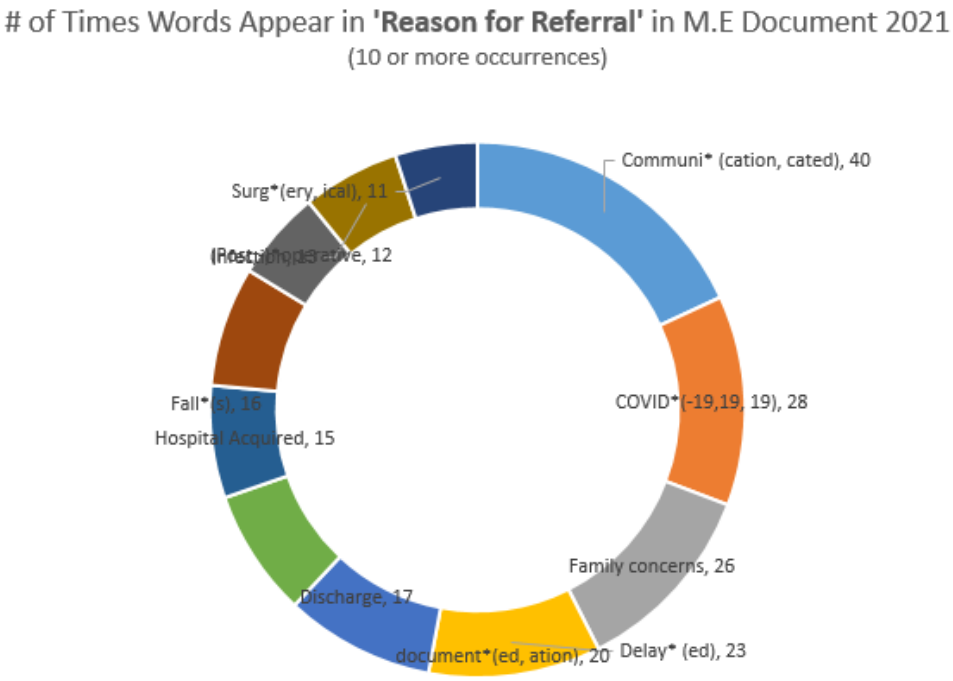


Figure 6 illustrates the commonly recurring words in the reason for referral as identified through a thematic synthesis of all referrals.

Figure 6



Communication

The most commonly recurring theme from ME referrals is communication, including family concerns relating to communication. Since the onset of Covid there have been visiting restrictions in place across all Health Boards, which has made contact and communication between patients, families and Health Board staff more challenging. In order to mitigate the implications of reduced visiting a telephonist services was deployed for a fixed period early in 2021 to provide a

dedicated phone line for relatives to ring and additional resource was provided to support switchboard. The Person Centred Care Team provided additional support to Patient and Family Liaison by utilising hospital Chaplains. Since the second wave of Covid volunteer activity has recommenced following robust risk assessment. The following quotes relating to communication have been received from the ME since July 2021:

"***Family concerns with regards to inconsistent information and infrequent updates"***

"It was three hours before the family were informed that their father had died"

"Lack of communication from the hospital… minimal information given to the family and only contacted once the patient had died"

"No communication from the hospital since the patients admission and did not know that he was dying"

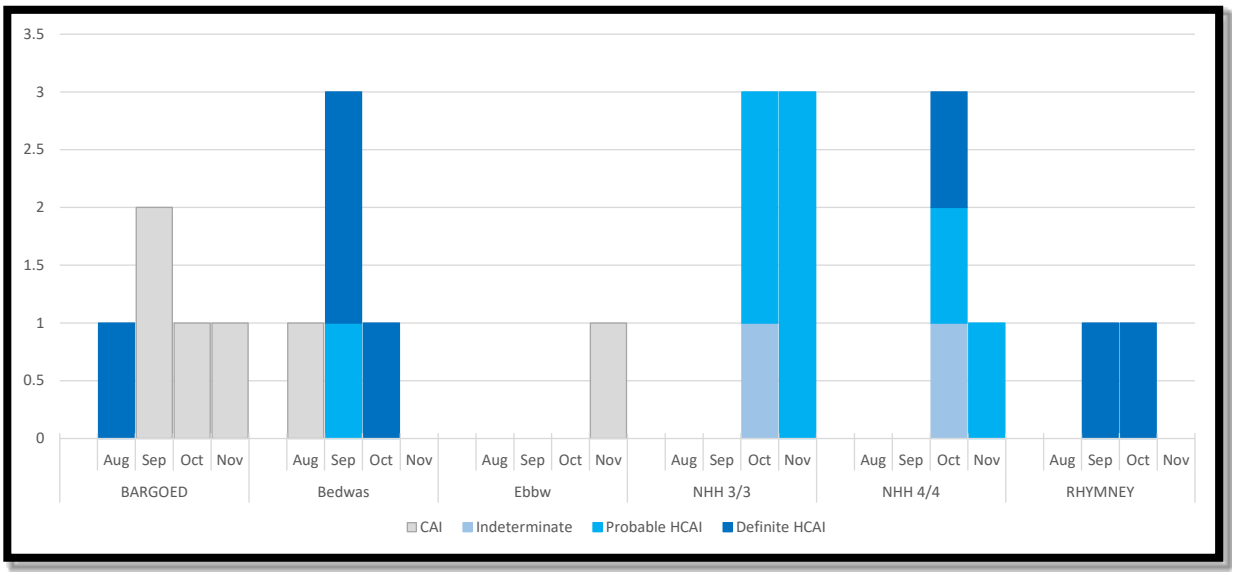
"Relative was referred from one hospital to the next and no one know where his mother was. Several days later a nurse took the time to locate her. "

In direct response to the concerns raised by the ME, a series of case note reviews are being undertaken to capture evidence relating to communication, communication plans, documentation of communication requirements and activity on handover documents completed when patients are moved between wards or sites with particular consideration given to communication at the end of life. The review will include utilisation of the end of life companions.

Covid

Pneumonia, Pneumonitis, Covid and pulmonary are the most commonly occurring words included in the cause of death, and although not universally associated with Covid, Covid related deaths were a dominant theme until February 2021 and continue to be a common cause of referral. All suspected or definite cases of nosocomial transmission are routinely referred back the Health Board for further review. There is a national framework for the investigation of Nosocomial Covid cases and therefore all ME referrals associated with probable or definite nosocomial transmission are shared with the IP&C team for consideration through this process.

Figure 7



The Covid-19 Patient Exposure Rapid Assessment Tool is used to assess for inpatients with a 'probable or actual' hospital acquired Covid-19 infection to extrapolate learning and identify causal factors. Reviews have been undertaken on 15 patients and have been presented at the Regional Nosocomial Transmission Group and have resulted in the following learning and improvements :

- A number of outbreaks have been identified as a result of the five day inpatient testing protocol and have identified patients that are asymptomatic carriers
- Staff are required to complete the pre shift screening questions and to obtain PCR tests if they become symptomatic.
- Checking of results is undertaken prior to moving patients from isolation to bays
- Ongoing monitoring of the daily covid assurance ensuring best practice
- Repeat testing if patients become symptomatic with chest infection
- Sharing of communal areas e.g toilets has been identified as increasing risk of transmission
- Not all patients able to tolerate face coverings
- Requirements for enhanced care

Intersite Transfers

Repeated transfers between hospital sites is a secondary recurring theme that is highlighted through family concerns and by the ME a contributing factor in a number of other reasons for referral including delays in treatment and failures in communication. Below are a number of quotes taken from ME referrals

"Transferred multiple times and not accepted by the receiving clinical team due to poor communication."

"Multiple transfers ... failure to assess before transfer "

"Concerns from family regarding several transfers."

"Multiple changes of team and interhospital transfers led to inconsistency especially over end of life care."

"It is documented that the patient is for discussion with ITU for escalation if they deteriorate and then the following day it is advised that they are "stepped down"

To further understand the issues relating to intersite transfers, 34 deaths occurring within 48 hours of transfer from an ELGH to GUH between January and July 2021 have been reviewed to capture thematic learning.

Of the cases reviewed there two emergent themes:

Ambiguity around the Treatment Escalation Plan – When the patients arrived in GUH they were assessed as not being suitable for further treatment or investigation. In several cases it was apparent from the notes that discussion with ITU staff, surgeons or anaesthetists prior to transfer were likely to have prevented an unnecessary transfer.

In a number of cases there was a delay in transfer of the patient to GUH. The lack of transfer practitioners out of hours to support the safe transfer of the patient was noted in two cases and delays in deciding to transfer was noted in a further two case. In one of these cases the clinical notes identify that the patient required urgent transfer that night, however the transfer did not occur until the following morning.

Improvement work is underway to ensure timely transfer for treatment and intervention for patients who have an urgent clinical need. This has included setting a time limit for transfer and actions to overcome any constraints relating to clinician to clinician conversations. An audit of timely surgical interventions for patients being transferred to GUH is currently underway.

Some specialities, including respiratory, are currently undertaking virtual multi-disciplinary team reviews and options are currently being explored to broaden this practice to support review of non-urgent patient transfers.

A further 13 deaths occurred within 48 hours of transfers from GUH to ELGH sites were reviewed. In all of the cases the patients were being treated conservatively and were not for escalation. It is not suggested that the transfers were responsible for hastening the patient's death and it was not observed that patients were being transferred when they were identified as being in their last days of life, however there were impacts on communication and continuity of care in some cases and there was one case where the patient did not have a Treatment Escalation Plan or DNACPR in place when transferred which resulted in an inappropriate resuscitation attempt.

Treatment Escalation Plans (TEP) were well utilised throughout the first wave of Covid and were effective in ensuring that decisions around treatment plans were

clearly documented and communicated. A recent audit has demonstrated a reduction in the use of TEP across the organisation and work is underway including the provision of training to clinicians to support improved uptake.

Discharge

Several ME referral have been made in relation to readmission soon after discharge. The following are quotes taken from ME referrals.

"Patient discharged home with no package of care, wife not coping patient sleeping of the sofa"

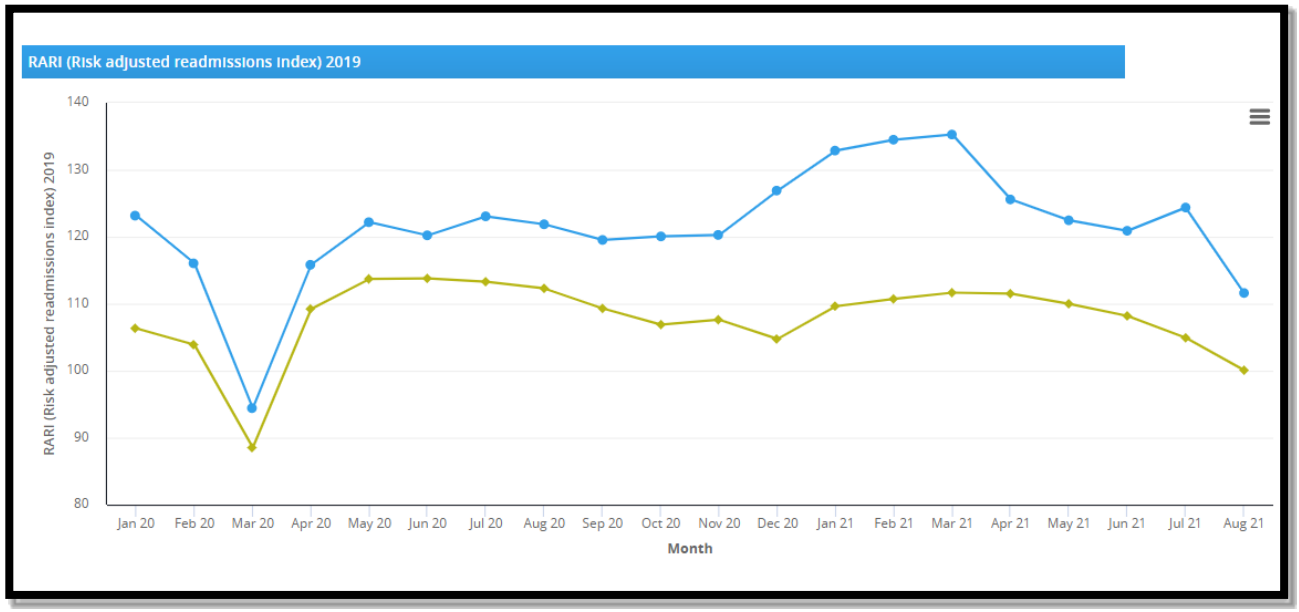
"Patient discharged home for end of life care but had to be brought back straight away as unable to access the room the patient was going to be cared in"

"Patient sent home on multiple occasions, barely able to stand , leaving an elderly spouse struggling to cope"

"Documentation that the patient could be discharged once bowels open but no documentation that this occurred. Readmitted the following day with worsening symptoms"

Figure 8 illustrates the ABUHB risk adjusted rate of readmission within 28 days of discharge compared to Welsh peers and demonstrates a consistently higher rate within the Health Board with a marked deterioration between November 2020 and April 2021.

Figure 8



A paper is being developed to present to the Discharge Board to support learning from the Medical Examiner reviews.

Prescribing

Steroid prescribing

There have been two Level 2 reviews which have highlighted learning relating to steroid prescribing. In both cases the prescribing was not instrumental in the patient's death.

- Failure to alter the prescribed oral steroid dose or alter the route of administration in a patient in a patient who was acutely unwell.
- Failure to reconcile the historical oral steroid prescribing which resulted in omission in prescribing.

Whilst there is an understanding when patients are on long-term steroids the dose should be reviewed when they are acutely unwell and admitted to hospital, there is no guidance available on how to manage a dose increase or a suggestion of increased dose.

Work is underway between Pharmacy and the endocrine directorate to ensure compliance with a recently issued Patient Safety Notice, PSN057 relating to safe prescribing and management of steroid replacement therapy. Part of this work will involve issuing an alert on steroid prescribing that should cover examples including non-optimal management of acute illness in patient on long-term steroid treatment and development of suitable guidance will be included as part of this action plan. Compliance with PSN057 will also look at other issues when prescribing courses of steroids and is subject for discussion at the ABUHB Medicines Safety Group.

Eltrombopag prescribing

- Development of a thrombosis following prescribing of Eltrombopag to treat idiopathic Thrombocytopenia secondary to the AstraZeneca Vaccination

Embolism and thrombosis is recognised as an uncommon side effect of Eltrombopag. The prescribing of Eltrombopag is limited to specialists in haematology and as a result the case has been presented to the haematology consultant group to reinforce that all patients commenced on Eltrombopag should have a clear risk benefit discussion documented in the notes all patients should be informed of the potential risk of thrombosis and in patients with atrial fibrillation in whom anticoagulation has been stopped, the rationale for this should be documented and clearly explained to the patient

Advanced care planning

The All Wales Advanced Decision to Refuse Treatment, is legally binding and the statement of wishes and preference Form is not legally binding but provides a strong direction for future care, are completed by individuals usually after an explanatory discussion with health care professionals and are an important resource for doctors, nurses and Paramedics when responding to an emergency.

Two referrals have been made by the Medical Examiner which have highlighted the need for robust care planning at the end of life.

In the first case a care plan had been formulated with the frailty team to avoid unnecessary hospital admission but challenges in sharing and communicating the plan led to the patient being admitted

The second case identified that an ACP was in place, however on further review it was established that this had been formulated without the involvement of the patient and when the patient did not have mental capacity to make the decision.

It has been agreed that relevant outcomes from the ME referrals will be presented at the recently reconvened ABUHB End of Life Board to support workstreams.

Thrombosis

A number of referrals have made by the ME service where it was noted that the patient had developed a thrombosis or where it was noted that thrombosis occurred in the cause of death.

Thrombosis occurrence increases with age and endogenous causes include cancer, obesity and clotting disorders while exogenous causes included hospitalisation, immobility and trauma, these causes can be mitigated. Hospital Acquires Thrombosis (HAT) are defined as venous thromboembolisms (VTE) that occur within 90 days of a hospital admission, the risk of them occurring can be mitigated by the appropriate VTE risk assessment and prescribing of VTE prophylaxis.

ABUHB has a robust process in place to identify all HAT review all HAT to establish if the occurrence was avoidable.

Figure 9 demonstrates that since June 2020 only two HAT have been identified as potentially avoidable and Figure 10 illustrates the areas of occurrence of HAT and the two clinical areas where avoidable HAT have been noted. There was one case that was deemed potentially preventable. A standardised approach to provide feedback to clinicians and specialities is being agreed through the ABUHB Thrombosis committee.

Figure 9

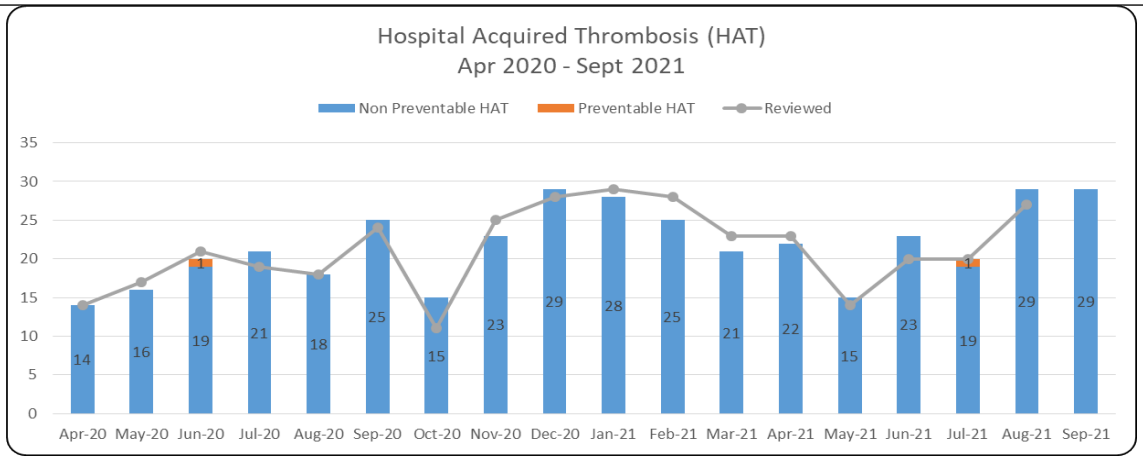


Figure 10

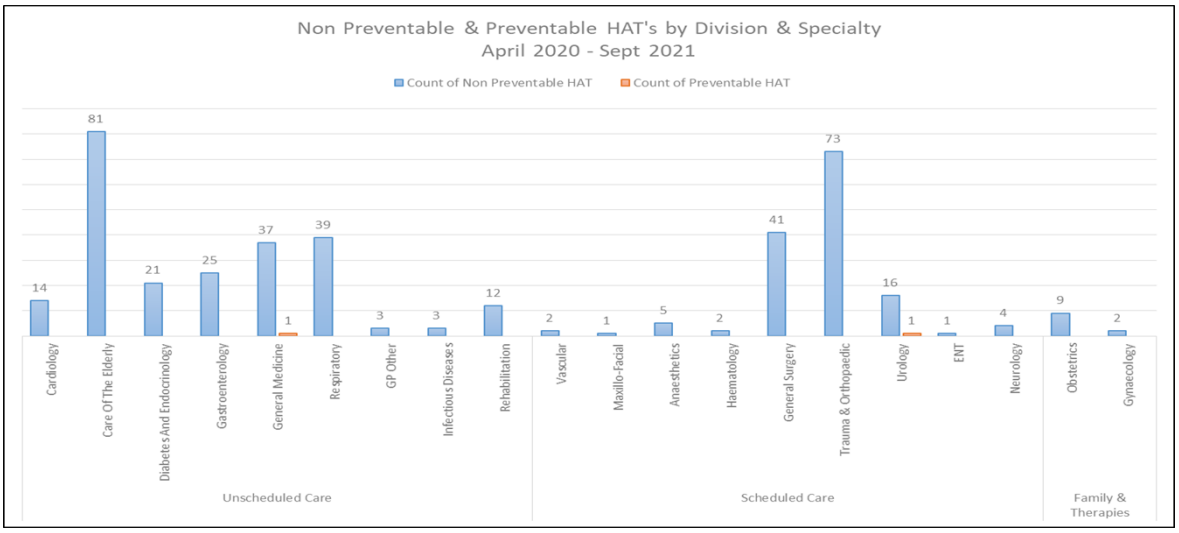
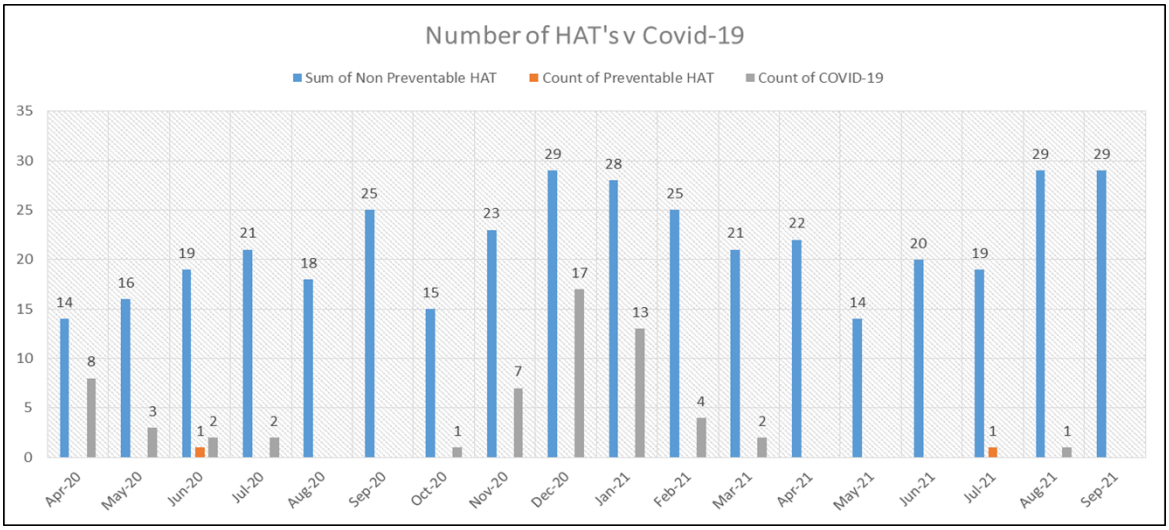


Figure 11 illustrates the occurrence of HAT associated with Covid

Figure 11



Condition specific Mortality

Myocardial Infarction (MI)

ABUHB mortality is above the Welsh mean as illustrated in Figure 12, but remains within two standard deviations when compared with Welsh peers. The ABUHB MI pathway means that out of hours the majority of patients presenting with an ST elevation MI (STEMI) will be conveyed directly to Cardiff and Vale UHB Cardiac Catheter lab or will be transferred to Cardiff and Vale if presenting to initially to GUH. As a result a significant proportion of MI data relates to Non ST elevation MI patients who have a higher mortality rate than those with STEMI. Figure 13 illustrates mortality associated with STEMI and NSTEMI.

Figure 12.

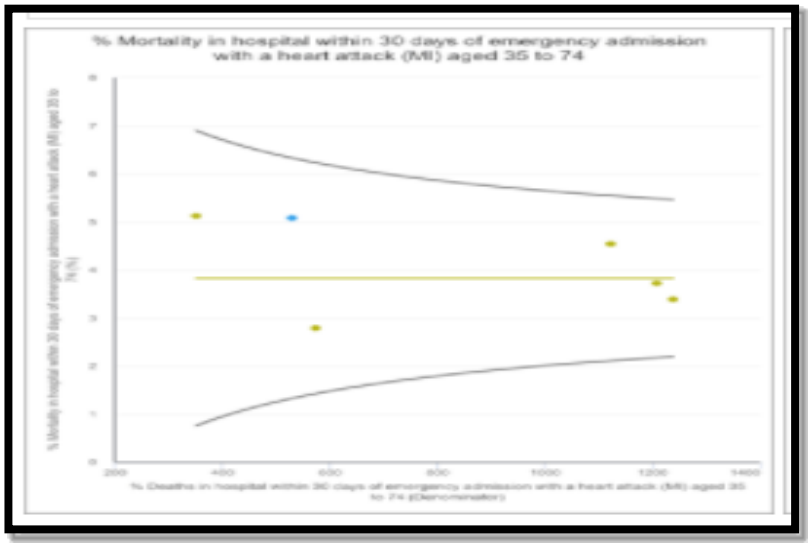
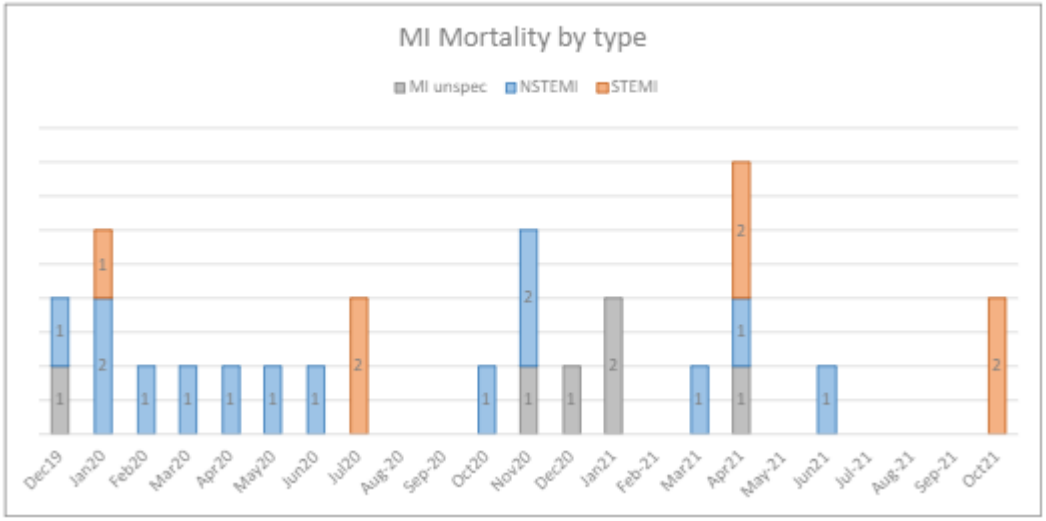
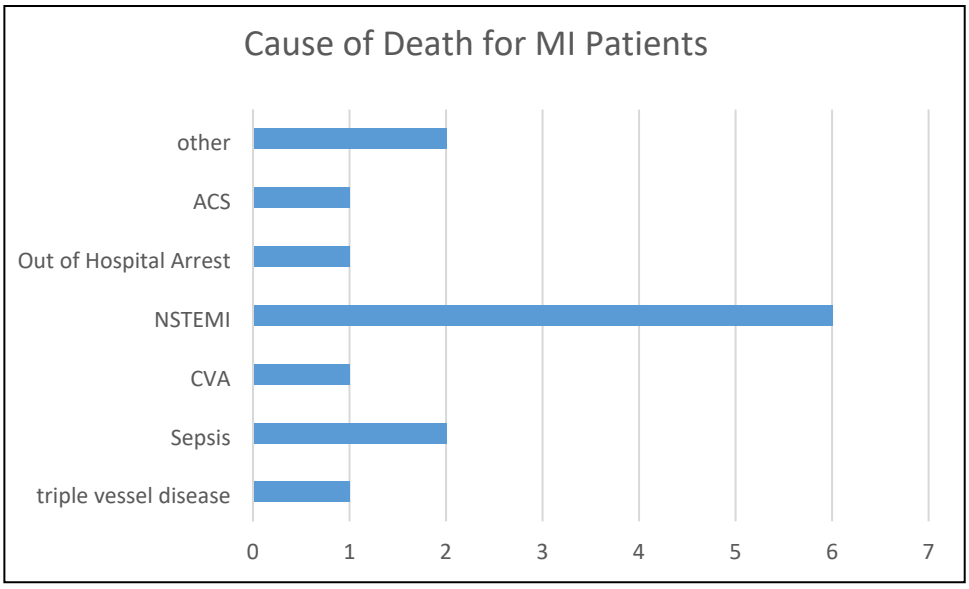


Figure 13



In June 2021 a review of MI inpatient deaths was undertaken and presented to the ABUHB Mortality review Group. In total there have been 14 MI deaths between February 2020 and March 2021. The most common cause of death was Non ST Elevation MI and the majority of the patients were noted to have multiple comorbidities. Only one patients had a diagnosis of COVID. Four patients died on the day of admission. 71% of the deaths were anticipated and all had DNACPR orders in place. The majority of patients were managed conservatively at the end of life.

Figure 14



5 of the cases review required a further consideration following a universal mortality review in two cases this was as a result of a dealys in documenting the DNACPR decision and in one case it was pending a routine coroner's referral as a result of the duration of time following a stent insertion

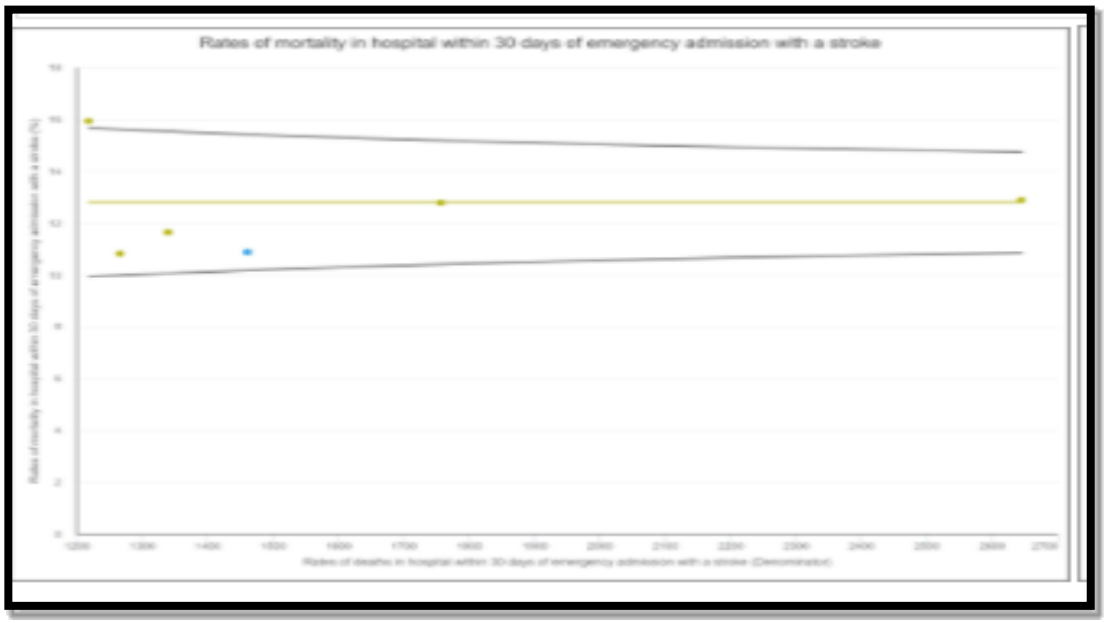
Stroke

ABUHB mortality is below the national mean as illustrated in Figure 15, and remains within two standard deviations when compared with Welsh peers.

In September 2021 ABUHB was informed by the Sentinel Stroke National Audit programme that the organisation was at alert level in relation to case adjusted mortality (SMR- Standardised mortality ratio) for the 2019/20 reporting period.

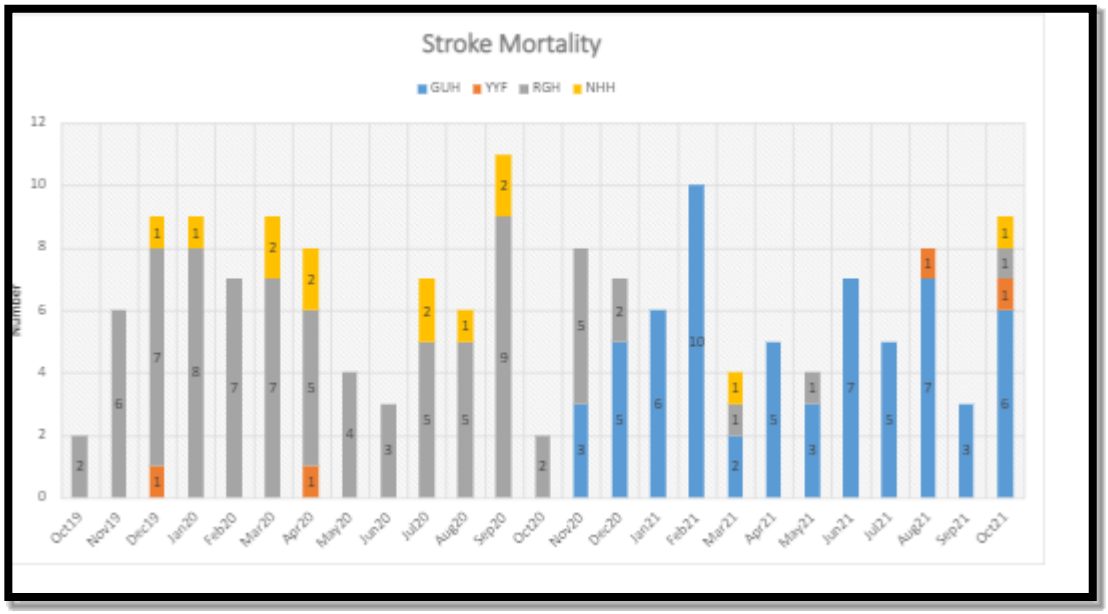
A review of the data demonstrated that the case ascertainment was accurate, however there was significant under reporting of comorbidities in particular atrial fibrillation and under reporting of reduced levels of consciousness both of which are important factors in case adjusting. A SSNAP data coordinator has recently been recruited which will support greater accuracy in submission of SSNAP data.

Figure 15



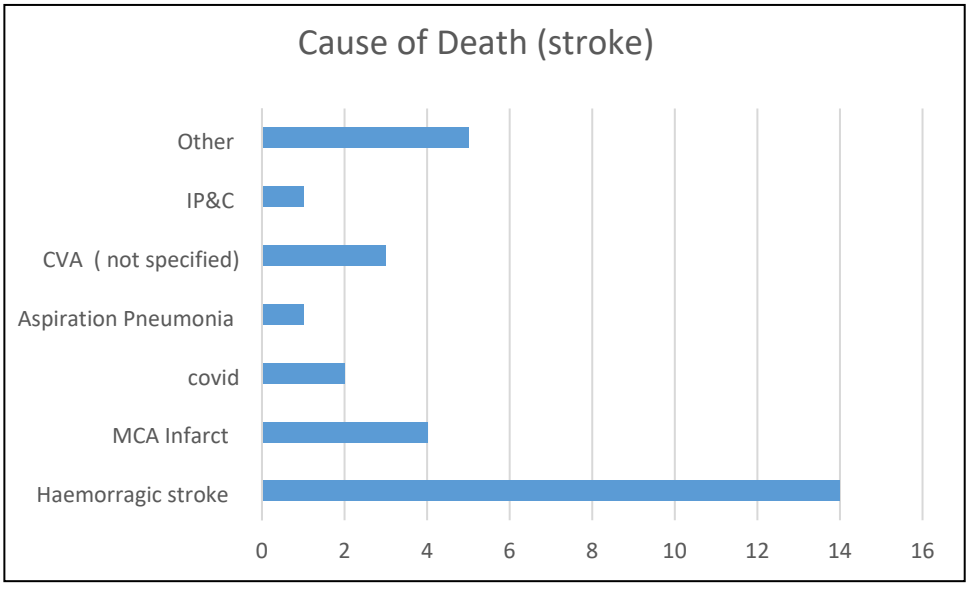
Since November 2020 acute the Hyper Acute Stroke Unit (HASU) has been situated in GUH and Figure 16 demonstrates the mortality spilt by site.

Figure 16



Stroke care has not emerged as a theme from ME referrals however it is subject to ongoing review at the ABUHB Mortality Review Group and the Health Board mortality position is considered in relation to other health boards across Wales. In June 2021 a review of 33 stroke inpatient deaths from April 2020 – March 2021 was undertaken and presented to the group. Of the 33 deaths reviewed the most common cause was haemorrhagic stroke. Of these cases subject to a universal mortality review 30 did not meet the threshold for a further consideration. One observation that emerged as a result of the review was the frequent and repeated ward moves that patients were subjected to following admission with a stroke

Figure 16



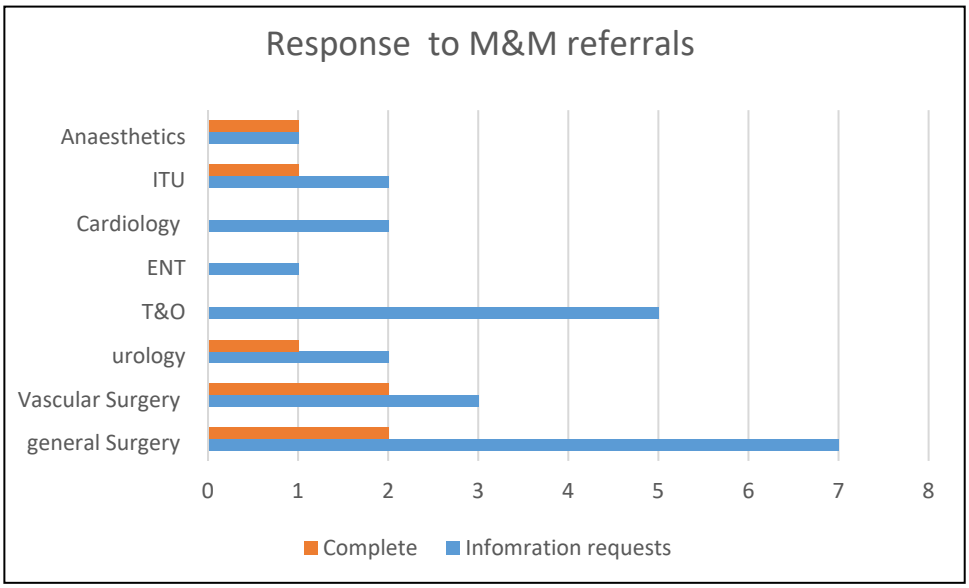
Post Invasive Procedure

As a result of scrutiny by the mortality review panel a number of requests for information consideration have been made to Morbidity and Mortality (M&M) meetings in a number of specialities.

The most common question asked of M&M meetings related to the level of risk assessment, consideration of ceilings of treatment and communication with the patient or their family around the risk and benefits of the procedure.

The majority of requests for information remain pending and further work will be taken undertaken support improved processes in relation contributing to the terms of reference of the reviews and in ensuring timely feedback to provide assurance and inform requisite improvements.

Figure 17



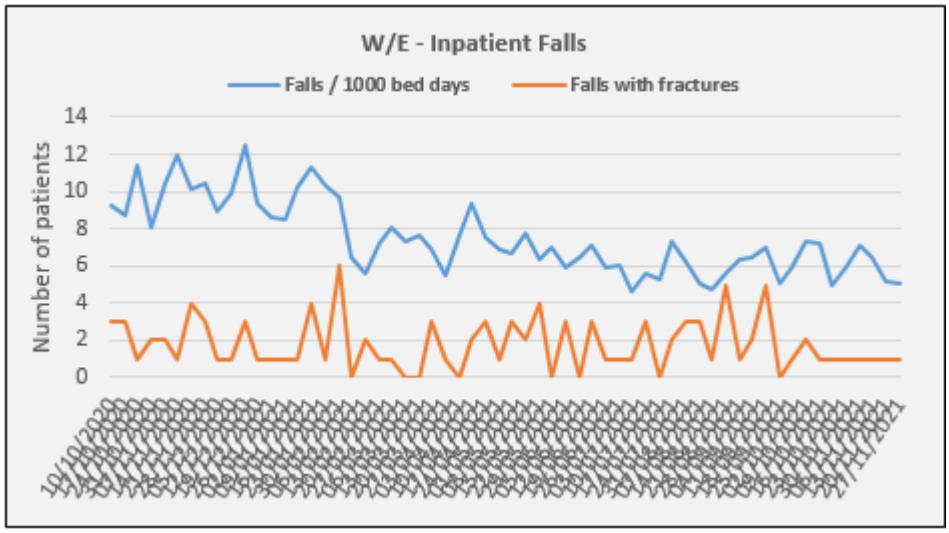
Falls

The ME routinely reviews all mortality cases to establish if the patient had fallen during their inpatient care or if they were admitted following a fall in their residential setting.

Of the 229 reviews considered 60 referenced patient falls as an inpatient or at home.

Figure 18 demonstrates that in patient falls have fallen since October 2020. In mid-December 2021 inpatient falls were recorded as 12,47 per 1000 bed days but have reduced to 5.02 per 1000 bed days by the week ending 28th November 2021.

Figure 18 Inpatient falls



Over the past 12 months the Inpatient Falls Policy has been revised and a new multi factorial risk assessment introduced. Falls prevention training has been made available to all hospital nursing staff and all inpatient falls that result in a fracture are presented at the falls review panel to support learning. Themes emerging from the review panel included compliance with accurate risk assessment and re assessment and challenges in enhanced care due to staffing pressure. A meaningful activity pilot is underway to support a revised approach to providing enhanced care.

Recommendation

The Committee is asked to:

NOTE the assurance provided by ABUHB's process to review and scrutinise care inpatient mortality

Discuss the learning and improvements that are being implemented where required.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report reviews high level data in order to highlight learning from death. The quality improvement initiatives in this report are being undertaken to improve patient safety and therefore reduce the risk of harm to our Patients. Improved patient safety also reduced the risk of litigation Issues are part of Divisional risk registers where they are seen as a particular risk for the Division and a

	number of areas are also included within the Covid and Corporate Risk Registers.
Financial Assessment, including Value for Money	Some issues highlighted within the report will require additional resources to support further improvement. These will be subject to individual business cases which will contain the full financial assessment. In many cases, improving the quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.
Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	As an assurance report, this paper does not require an Impact Assessment.
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care. Many of the themes reported in the paper have been discussed and presented at ABUHB groups that from part of the quality assurance framework
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety

	improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	
Public Interest	Report has been written for the public domain.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality Safety and Outcomes Committee 21 December 2021 Agenda Item: 2.5

Executive Summary	
Patient Quality, Safety and Outcomes Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Leanne Watkins, Director of Operations	
Authors: Rhys Shorney/Gareth Hughes	
Date of the Report: 08/12/2021	
Supplementary Papers Attached: Yes	

Purpose of the Report

To provide assurance to the Patient Quality, Safety and Outcomes Committee in respect of Enhanced Cleaning Standards, as presented at Executive Team September 2021.

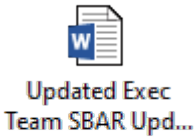
Background and Context

This paper attached was approved by the Executive Team on 13th September 2021 and is intended to provide detail further to the All Wales Enhanced Cleaning Standards (Covid 19 Addendum).

The Executive Team supported Option 2 - fixed term recruitment to COVID/Surge domestic requirement on a 12/24 month basis (51.64wte with a potential financial risk of £1.293m) which will allow reallocation of agency staff to support delivery of the Enhanced Cleaning Standards in terms of cleanliness and patient safety.

Since the re-opening of the hospitality sector, domestic agency labour supply has greatly reduced to a level where the Division is unable to meet current demands on sickness absence backfill, COVID/Surge additional requirements and the Enhanced Cleaning Standards.

This option is deemed the lowest financial risk to the Health Board whilst limiting operational risk based on the assumption that the Enhanced Cleaning Standards and funding cease on 31st March 2022.



Assessment and Conclusion

The initial focus was recruiting to our surge and Covid capacity requirements which are detailed below:

- increase contracted hours of existing staff
- recruited 20 WTEs
- recruited a further 10 WTEs via the 'recruitment bus
- recruited 10 people via the kickstart scheme

The focus then shifted to recruiting 88 WTEs to deliver the enhanced standards:

- So far, 17 WTEs have been inducted
- 30 more are expected next week
- The recruitment agency anticipate the remaining requirement to be filled by the end of January 2022

The Facilities Team are continuously working closely with clinical/nursing teams and infection control staff in delivering the standard.

Recommendation

The Patient Quality, Safety and Outcomes Committee is asked to note the progress of recruitment against the SBAR.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risks detailed with the Estates and Facilities Divisional Risk register
Financial Assessment, including Value for Money	Financial commitment is in line with the SBAR attached.
Quality, Safety and Patient Experience Assessment	Risks detailed with the Estates and Facilities Divisional Risk register.
Equality and Diversity Impact Assessment (including child impact assessment)	As an assurance report, this paper does not require an impact assessment. An Equality and Diversity Impact Assessment was conducted and is attached to the SBAR.

Health and Care Standards	
Link to Integrated Medium Term Plan/Corporate Objectives	The all Wales Enhanced Cleaning Standards (Covid 19 Addendum) is detailed in the Estates and Facilities Divisional IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The all Wales Enhanced Cleaning Standards (Covid 19 Addendum) compiles with the Well-being of Future Generations (Wales) Act 2015 – 5 ways of working
Glossary of New Terms	N/A
Public Interest	N/A

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Executive Team: Updated Briefing Paper - All Wales Enhanced Cleaning Standards (Covid 19 Addendum)

Document Title:	Updated Briefing Paper further to the - All Wales Enhanced Cleaning Standards – Covid 19 Addendum SBAR (Presented 13th September 2021)		
Date of Document:	22nd September 2021		
Executive Sponsors:	Leanne Watkins, Director of Operations & Rhiannon Jones, Executive Director of Nursing		
Authors:	Rhys Shorney – Facilities Manager, Michelle Key – Service Improvement Manager, Stacey Mahoney – Workforce Business Partner, Rob Gordon – Business Partner Accountant		
Purpose: **Exec. Team is asked to:**	Approve change		Comment:
	Approve funding	X	
	Provide a view		

Summary / Situation:

This paper is intended to provide detail further to the All Wales Enhanced Cleaning Standards (Covid 19 Addendum) SBAR presented to the Executive Team by Gareth Hughes, Divisional Director of Estates & Facilities, on Monday 13th September 2021.

The Executive Team are asked to support Option 2 - fixed term recruitment to COVID/Surge domestic requirement on a 12/24 month basis (51.64wte with a potential financial risk of £1.293m) which will allow reallocation of agency staff to support delivery of the Enhanced Cleaning Standards in terms of cleanliness and patient safety.

Since the re-opening of the hospitality sector, domestic agency labour supply has greatly reduced to a level where the Division is unable to meet current demands on sickness absence backfill, COVID/Surge additional requirements and the Enhanced Cleaning Standards.

This option is deemed the lowest financial risk to the Health Board whilst limiting operational risk based on the assumption that the Enhanced Cleaning Standards and funding cease on 31st March 2022.

Background:

Pre Covid-19 Cleaning Standards

Environmental cleaning of NHS healthcare settings in Wales, is currently completed in accordance with the National Standards for Cleaning in NHS Wales. The Standards, first published in 2003 and revised in 2009 provide a framework from which each Health Board should develop a Cleanliness Strategy, Operational Cleaning Plan and agreed frequencies of cleaning. The

document sets out the minimum standards of cleanliness that should be achieved across the NHS Wales estate.

Surge/COVID Requirement

In addition to the approved day 1 GUH/eLGH model, since the beginning of the pandemic in March 2020 and opening of GUH November 2020, a review of services has been carried out and additional workforce is required due to; COVID, surge demands, bed configuration, and reintroduction of service models (patient feeding, cleaning, portering). This equates to an additional 51.64WTE domestic staff (total across all facilities services 172.04WTE). This requirement is currently being met by agency staff.

Covid-19 Changes to Cleaning Standards

In October 2020, a specific Covid-19 Addendum to the 2009 Standards were implemented, to ensure appropriate level of environmental cleaning across the NHS Wales estate. In total the addendum included 9 standards of cleanliness. The most significant change from the core Standards was Standard 2 – cleaning frequencies. Standard 2 included three tiers of cleaning frequencies listed as 'red', 'amber' and 'green' pathways. Overall, each pathway provided increased cleaning frequencies (from the core 2009 Standards) that varied by pathway and area (refer to Appendix 1).

A collaborative review of the workforce requirement to deliver the Standards was undertaken by the Senior Facilities Management Team, Service Improvement Manager for Cleaning Services, Operational Services Managers and Business Partner Accountant. The group reviewed pre-pandemic cleaning schedules, resource allocation and environmental audit reports to determine the required level of resource to deliver the Standards.

In considering the likelihood of all areas presenting a red pathway, this was deemed as low and would subsequently present a high recruitment risk. Therefore, using a pragmatic and risk based review of the workforce modelling across the three pathways, it is assumed that the demand will be 100% of the green pathway (88WTE) with the remaining (39WTE) for amber and red pathway requirements which will be flexed according to demand. Total requirement is 127WTE.

The full year cost of providing the Enhanced Cleaning Standards on a fixed terms basis is £3.9m consisting of £3.574m for 127wte Band 2 staff and £357k for cleaning consumables. **At present, Welsh Government have not confirmed a continuation of the amended standard or an allocation of funding to ABUHB beyond 2021/22 financial year.**

This workforce requirement was benchmarked and aligned to other NHS organisations in Wales and accounted for the number of single bedded rooms and subsequent additional cleaning requirements across ABUHB sites.

It is important to note that this is an estimate of where we are now based upon current modelling and informed assumptions, and will require a continual review to account for any unforeseen changes.

Assessment

(strategic impact or escalation as decision required is outside of delegated authority):

Workforce Position and Challenges to Date

This section provides context of the current workforce position and challenges delivering the Enhanced Cleaning Standards.

The table below outlines the current service models (Day 1, Temporary Services / COVID /Surge and Enhanced Cleaning Standards) and the demands on workforce supply.

Domestic	Total WTE
Total day 1 - ET Approved WTE	299.31
Total Substantial Staff in Post	**299.31**
Temporary Services / COVID / Surge - WTE Requirements	51.64
Temporary Enhanced Cleaning Stardards - WTE Requirements	127.00
Total Demand for Agency WTE	**178.64**

In July 2020 the Executive Team approved 299.31wte as part of the day 1 model. There are no increased requirements in delivering the approved day 1 plan.

In addition to the day 1 model, since the opening of GUH and reconfiguration of eLGH sites, a review of services has been carried out and additional workforce is required due to; new clinical service models, centralisation/updated assumptions, COVID/Surge/Temporary demands i.e. additional wards opening and services to support the local bronze/site management groups. This equates to a temporary additional 51.64wte which is currently resourced through the use of agency staff.

Therefore, the temporary additional demand on domestic agency support above day 1 (excluding for the delivery of the Enhanced Cleaning Standards) is 51.64wte, which is proving a challenge to resource.

In addition, Enhanced Cleaning Standards requires an additional 127wte. If internal recruitment options are therefore not explored, the demand on agency staff for domestic services alone will be 178.64wte. This level of agency reliance is not sustainable and as such delivery of the Enhanced Cleaning Standards via this supply route would be difficult to achieve for the following reasons:

- Limited resource to support the increasing administration associated with the pay process and paper timesheet management of agency staff
- The regular turnover of agency staff (currently at 10%) would impact the consistency of cleaning on ward areas and would cause increased risk for service delivery. This also has a

financial impact of having to re train more agency staff which already is taking place on a regular basis.

- Whilst the division has increased its use of agency providers to support with the increased service demands, it is highly unlikely the division would be in a position to source enough agency supply to meet the additional workforce requirements.
- High usage of agency has had a detrimental impact on substantive staff (training and shadowing).

Sickness Absence

In addition to the challenges outlined above to support with increased service demands, it is worth highlighting that current sickness levels also present ongoing challenges as the division are also relying on agency to fulfil these gaps. As at Sept 2021 sickness absence percentage for all Facilities staff is 10.74% (95.37wte). In terms of backfill of this sickness for domestic staff, this equates to 10.49% (31.40wte) which are mainly sourced via agency and do not form part of the table above.

Turnover

In reviewing the level of domestic staff turnover over a rolling three year period Aug 2018 – Aug 2021 (both pre and post pandemic), the annual turnover rate and number of leavers is 2.65% (7.93wte).

Option Appraisal:

In taking into account the current workforce challenges and position to date, the division have considered the most appropriate means of resourcing the additional 127wte domestic workforce. The three options for consideration are:

1	Continue to use agency staff to meet COVID/Surge and Enhanced Cleaning Standards Demand
2	Support fixed term recruitment to COVID/Surge demand 12/24 months and utilise agency for Enhanced Cleaning Standards (PREFERRED OPTION)
3	Recruit to COVID/Surge requirement and Enhanced Cleaning Standards for 12/24 months fixed term

Full financial and risk appraisal can be found in **Appendix 2**.

The preferred option is 2, which would support staffing requirements for COVID/Surge on a fixed term basis to release agency staff to support the Enhanced Cleaning Standards. It is assumed that the COVID/Surge requirement will remain for the foreseeable future and therefore deemed low risk to recruit into on a fixed term basis. The potential financial risk, should the Enhanced Cleaning Standards funding and requirement cease on 31st March 2022, is as follows:

Year 1 - £0 (funded by Welsh Government until 31st March 2022)
Year 2 - £1.293m / 51.64wte (based on 1 year fixed term)
Year 3 - £1.293m / 51.64wte (based on 2 year fixed term)

Whilst it is recognised that this option may pose a level of workforce and financial risk, it is anticipated that these risks will be mitigated as follows:

- The turnover position reveals a minimum of 7.93wte per year within the domestic service that will require ongoing vacancy fill as part of core requirement. If recruited under multi-skilled roles, they could fill additional recruitment requirements
- Domestic sickness is currently 10.49% (31.40wte) which could be covered by staff supported in this paper should COVID/Surge demand decrease
- Local Health Board's in Wales were working in partnership with NWSSP to agree new and updated standards of cleanliness. In their current form the proposed cleaning frequencies are closely aligned to the Covid 19 Enhanced Cleaning Standards.
- Recruitment of roles will reduce agency expenditure and usage providing a more flexible workforce that can be effectively drawn upon to support areas of need. This will reduce associated time pressures and costs linked to agency recruitment and payment process but will also support a more sustainable, skilled workforce that can deliver and fulfil service demands.
- Roles will be advertised and recruited against a Facilities Operative Job Description. This will enable individuals to be fully trained in dual disciplines i.e. in catering and cleaning allowing greater potential for staff movement and support should service demands change.

A September report by the CIPD has in fact outlined that in this uncertain period, employers need to 'bite the bullet' and start hiring individuals with the view to increasing job security in order to attract and retain candidates. This option therefore provides a more sustainable means to increasing supply and delivery of the standards through becoming an employer of choice and limiting workforce supply through the loss of potential candidates to market competitors.

As highlighted there are risks attached to each of the options proposed to the Executive Team, in terms of finance and workforce recruitment and retention. The biggest risk will be to continue as we are as this may not only result in the Enhanced Cleaning Standards not being delivered, but will also maintain, or even worsen, the gaps in core service provision. **The current workforce gaps, particularly the supply of workforce to deliver the additional cleaning services required at the majority of sites could result in healthcare acquired infections increasing. This paper has set out the importance of cleaning in the effort to reduce such infections.**

Each of the additional cleaning requirements requested by site leadership teams has been reviewed by senior IPAC colleagues, and very little is able to be safely scaled back. Although no assurances can be given relating to the Enhanced Cleaning Standards timeline, the addition of these posts will underpin the delivery strategy. It is imperative that the core standards are safely delivered in advance of increasing cleaning frequencies.

Recommendation / Conclusion

The Executive Team are asked to support Option 2 - fixed term recruitment to COVID/Surge domestic requirement on a 12/24 month basis (51.64wte with a potential financial risk of £1.293m) which will allow reallocation of agency staff to support delivery of the Enhanced Cleaning Standards in terms of cleanliness and patient safety.

Since the re-opening of the hospitality sector, domestic agency labour supply has greatly reduced to a level where the Division is unable to meet current demands on sickness absence backfill, COVID/Surge additional requirements and the Enhanced Cleaning Standards.

This option is deemed the lowest financial risk to the Health Board whilst limiting operational risk based on the assumption that the Enhanced Cleaning Standards and funding cease on 31st March 2022.

Appendix 1

High-Risk COVID-19 Pathway Section 9: SICPs & TBPs	Medium Risk COVID-19 Pathway Section 8: SICPs & TBPs	Low Risk COVID-19 Pathway Section 6: SICPs
Any care facility where: a) untriaged individuals present for assessment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 (COVID-19) positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results OR d) symptomatic individuals who decline testing	Any care facility where triaged/ clinically assessed individuals are asymptomatic and are: a) waiting a SARS-CoV-2 (COVID-19) test result and have no known recent COVID-19 contact OR b) where testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR c) asymptomatic individuals who decline testing in any care facility	a) Any care facility where triaged/clinically assessed individuals no symptoms, no known recent COVID-19 contact, who have isolated/shielded AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the point of the test OR b) patients who have recovered from COVID-19 and had at least three consecutive days without fever or respiratory symptoms and a negative COVID-19 test OR c) patients or individuals in any care facility where testing is undertaken regularly (remain negative)

	High Risk Pathway - Daily frequency	Medium Risk Pathway - Daily frequency	Low Risk Pathway - Daily frequency
Occupied Emergency / Assessment Areas	4 times	3 times	Twice
Inpatient rooms / cohort – occupied	3 times	3 times	Twice
Private Patient bathrooms/ toilets	Twice	Twice	Twice
Inpatient rooms – unoccupied (terminal cleaning)	When vacated and then twice daily	When vacated and then twice daily	When vacated
Occupied inpatient areas	3 times	3 times	Twice
Shared patient bathrooms/ toilets	4 times	3 times	Twice
Unoccupied inpatient areas	Twice	Once	Once
Outpatient / ambulatory care rooms	Between patients	Between patients	Twice
Frequently used hallways and corridors	Twice	Twice	Twice
Frequently touched areas in hallways and corridors	4 times	4 times	Twice
Hallways and corridors that are not frequently used	Once	Once	Once
Outpatient / ambulatory care rooms	Between patients	Between patients	Between patients

Appendix 2

The following table assumes the Enhanced Cleaning Standards funding and requirement ceases 31st March 2022:

Option	Description	WTE	Potential Financial Risk £000			Financial Risk	Operational Risk
			2021/22	2022/23	2023/24		
1	**Continue to use agency staff to meet:**					No cost pressure as agency can be stopped from 1st April 22 where appropriate	Not able to secure agency staff to this level to meet surge COVID, Enhanced Cleaning Standards. Quality control risk.
	COVID/Surge (agency)	51.64	0	0	0		
	Enhanced Cleaning Standards (agency)	127.00	0	0	0		
		178.64	**0**	**0**	**0**		
2	**Support fixed term recruitment to COVID/Surge requirement 12/24 months and utilise agency for Enhanced Cleaning Standards (PREFERRED OPTION):**					Risk can be reduced as can re-direct resource to Enhanced Cleaning Standards, sickness backfill (10.49%, 31.40WTE) and vacancy requirements (2.65% pa, 7.93WTE pa)	Able to deliver against COVID/Surge resource demand. Not able to secure agency staff to this level to meet Enhanced Cleaning Standards. Quality control risk.
	COVID/Surge (fixed term)	51.64	0	1,293	1,293		
	Enhanced Cleaning Standards (agency)	127	0	0	0		
		178.64	**0**	**1,293**	**1,293**		
3	**Recruit to COVID/Surge requirement and Enhanced Cleaning Standards for 12/24 months fixed term:**					Full financial risk potentially offset by redirecting resource to sickness backfill (10.49%, 31.40WTE) and vacancy requirements (2.65% pa, 7.93WTE pa)	Able to deliver against COVID/Surge resource demand plus Enhanced Cleaning Standards.
	COVID/Surge (fixed term)	51.64	0	1,293	1,293		
	Enhanced Cleaning Standards (fixed term)	127	0	3,931	3,931		
		178.64	**0**	**5,224**	**5,224**		

Further considerations	*WTE*
Sickness backfill with agency (facilities wide excl domestic) 10.74%	64.65
COVID/Surge currently met by agency (excl domestic)	120.85

Aneurin Bevan University Health Board

Health Board Committee Update Report

Name of Group:	Quality and Patient Safety Operational Group (QPSOG)
Chair of Group:	Peter Carr, Executive Director of Therapies and Health Science
Reporting to:	Patient Quality, Safety and Outcomes Committee
Reporting Period:	From the meeting held 10th November 2021 (held by Teams)

Summary of Key Matters Considered by QPSOG:

Divisional Risk Registers/Concerns

The Divisional Quality and Patient Safety leads presented their Division's highest risks and concerns related to quality and patient safety.

All Divisions noted the ongoing challenges and related risks in delivering safe care in the context of the COVID 19. Divisions confirmed that they have been fully supported in maintaining the necessary measures and protections.

Both Unscheduled Care and Scheduled Care Divisions highlighted the risk associated with increasing emergency demand and the ability to maintain safe assessment areas and flow.

The increased level of acuity in the hospitals and the associated increased demand for enhanced care and was noted by Unscheduled Care, Scheduled Care and the Community Divisions.

Scheduled Care highlighted the challenges with maintaining a safe green pathway for surgery.

Both the Family and Therapies and the Mental Health and Learning Disabilities Divisions noted the ongoing risk to children and young people suffering with acute mental health issues being admitted to the adult unit. It was noted that this issue has been escalated to the Executive Team and at all-Wales level, including with WHSSC for action to address.

Concern was noted in relation to WAST escalation when this causes the closure of birthing units and home births being suspended; this is happening on a more frequent basis due to the continued and increasing emergency demand and system pressures.

Injurious inpatient falls remain a high risk across all Divisions, though an overall reduction in inpatient falls has been seen through 2021, with marked improvement in community hospitals.

Staffing pressures within district nursing were noted as an increasing risk, compounded by recruitment difficulties, poor staff retention, sickness, medical exclusion and an increase in palliative care referrals. The Primary Care and Community Division has developed a plan which is being implemented to mitigate the risk.

The Complex Care Division noted the ongoing risks associated with care homes routine governance visits; some improvement was noted now that visits have been reintroduced. The continued fragility of the care home sector was noted.
Concern about the condition of the Health Board estate in some areas (older buildings) was flagged, noting that the six facet survey is due to be completed again and risk mitigation action is in place.
There was a general view across the Divisions that they have benefitted from the additional support given to strengthen the Divisional quality and patient safety resource and infrastructure, which is allowing an increased focus on the quality and safety agenda and facilitating improvements and addressing risks.
All the Divisional risks and concerns highlighted are included in the Divisional risk registers with information detailing the mitigation action being taken. The QPSOG was assured that the appropriate action is in place at Divisional level to address and mitigate the highlighted risks to ensure the quality and safety of services.

Quality, Patient Safety and Experience Report

A verbal report was presented and comments invited ahead of the formal report being prepared for presentation to the PQSOC meeting in December 2021.

Paediatric Peer Review of Essential Services

The group received an update with regard a recent review of paediatric services with a focus on pandemic recovery. Public health nursing was considered in relation to childhood immunisation. There was also a look at elective waiting times for children, with waits being of concern in ENT. Significant increased demand in audiology was also noted. The increase in virtual appointments within CAMHS services throughout the pandemic was recognised. Also, as expected, there has been an increase in safeguarding referrals since the schools reopened.
Paediatric services are responding to the review and plans being developed to respond to recommendations.

RLDatix Once for Wales Concerns Management System

The group received an update about the roll out of the RLDatix modules on feedback, claims and redress, which went live within the Health Board on 1st October. It was noted that there is still some work to do with retrieving the data out of the system, however the October data is comparable with normal averages. Work is ongoing with Informatics to incorporate the use of Clicksense.
The group were informed that the incidents module is planned to go live on 1st December and work is underway to ensure the platform is ready with access, permissions, IG and testing.
A programme of training for users is being developed.

Liberty Protection Safeguards

The group received an update on the replacement of the Deprivation of Liberty Safeguards (DoLS) which were due to be replaced in April 2022, which has been delayed by the Welsh Government. The Welsh

Government implementation group remains active and a workforce and training implementation plan is in place but is on hold currently. The five Gwent Local Authorities and the Health Board are involved and raising awareness. The Health Board continues to prepare for implementation and is in the process of developing a training strategy and has gained funds for employing practitioners and practice educators. In the meantime, DoLS remains the current legal framework. **Health & Care Standards 3.1 Clinically Effective Care** The group received an overview of the standard as part of the annual assurance report which will be provided to the Committee.
Matters Requiring QPSC Level Consideration:
• Quality, Patient Safety and Experience Report (scheduled for PQSOC meeting in December 2021) • Health & Care Standards 3.1 Clinically Effective Care annual assurance report (scheduled for PQSOC meeting in December 2021)
Key Risks and Issues/Matters of Concern
There were no key risks or matters of concern to note other than those already noted above.
Date of Next QPSOG Meeting: 18th January 2022

Patient Quality, Safety and Outcomes Report

Executive Summary

- Inpatient falls are at 5.02 per 1000 bed days, one of the lowest levels seen over the past two years.
- Clostridium difficile rate remain higher than target however it is an improving picture.
- Covid outbreaks are being identified through the routine 5 days testing programme, with 5 reported Ward outbreaks during quarter 3, all associated with asymptomatic spread.
- ABUHB has the lowest rates of infection in 4 of the 6 nationally reported infections.
- A review of Primary Care resource measured against a Health Board bench mark or 1 session per 200 patients has been undertaken and a local enhanced service is being developed to support increased sessions.
- 2021 performance data for stroke shows a declining position across a range of the Quality Improvement Measures. ABUHB is not unique in seeing its stroke performance deteriorate through the course of 2021, and with most of its quality metrics ABUHB compares positively against other Health Boards in Wales but improvements are required.
- Urgent and Emergency care remains a significant risk, with challenges based on the numbers of patients presenting impacting on ambulance handover times, ED transit times and the regular escalation of WAST in terms of their Clinical Safety Plan and ability to respond to community demand in a timely manner.

Quality & Patient Safety Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	X
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Clinical Executives	
Main Authors: Alexandra Scott, Assistant Director of Quality and Patient Safety Tracey Partridge-Wilson, Assistant Director of Nursing – Quality, Safety and Patient Experience Karen Hatch, Assistant Director of Therapies and Health Science	
Date of the Report: 7th December 2021	
Supplementary Papers Attached: Nil	

Purpose of the Report

The patient quality and safety report is produced around the themes of the Health and Care Standards (HCS) and is intended to provide assurance and stimulate discussion in relation to priority areas that are deemed to be higher risk. It has been agreed that a proportionate approach to reporting will be implemented for the winter period, based on key risks, with greater information and focus on the red RAG-rated areas.

Background and Context

The report is generated using key performance indicators, information from incident reporting, concerns and complaints and includes escalation from any of the quality & safety-associated groups which report to the Quality, Patient Safety Operational Group (QPSOG) and directly to the Patient Quality, Safety and Outcomes Committee (PQSOC).

The following is an 'at a glance' Red, Amber, Green (RAG) rated summary of key metrics that are regularly monitored, some of which (and importantly the 'red' rated areas) are included within this report, providing an overview of the Health Board position for quarter 2 and in some instances quarter 3 depending on data availability. The red RAG rated areas remain static from the last reporting period.

Assessment

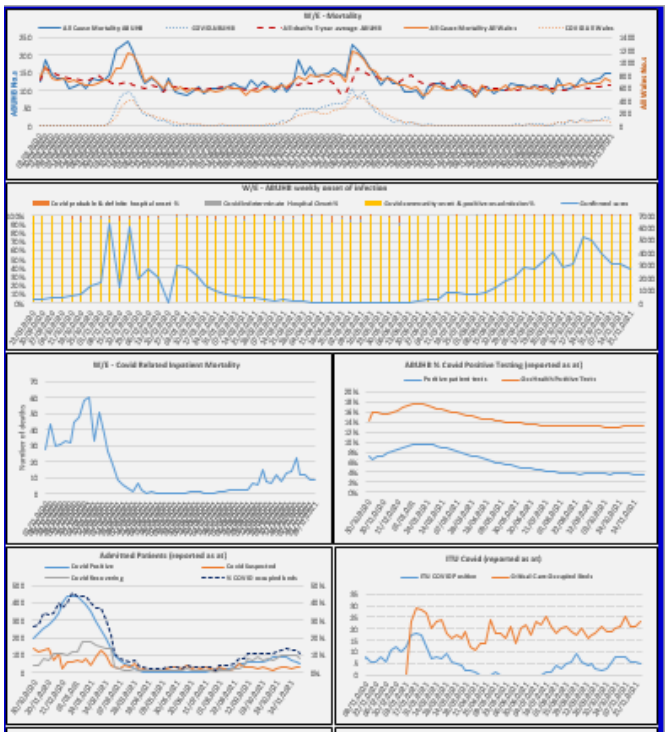
Safe Care

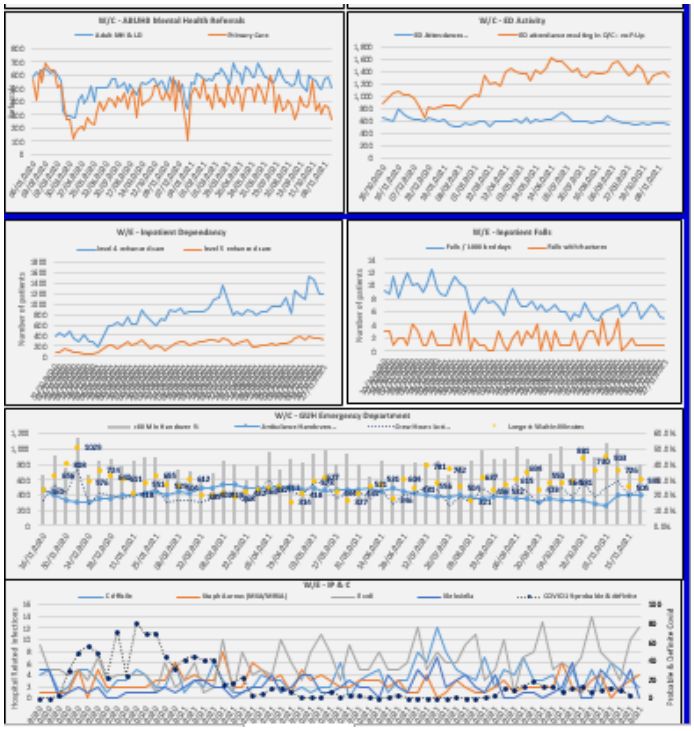
The principle of safe care is to ensure that the population are protected from harm and supported to protect themselves from known harm. The health, safety and welfare of people are a priority. A service focused on safe care and support is continually looking for ways to be more reliable and to improve the quality and safety of the service it

delivers. Although the provision of care has some associated element of risk of harm to service users, safe care identifies, prevents or minimises unnecessary or potential harm. People will be kept safe and protected from avoidable harm through appropriate care, treatment and support.

Leadership and Governance

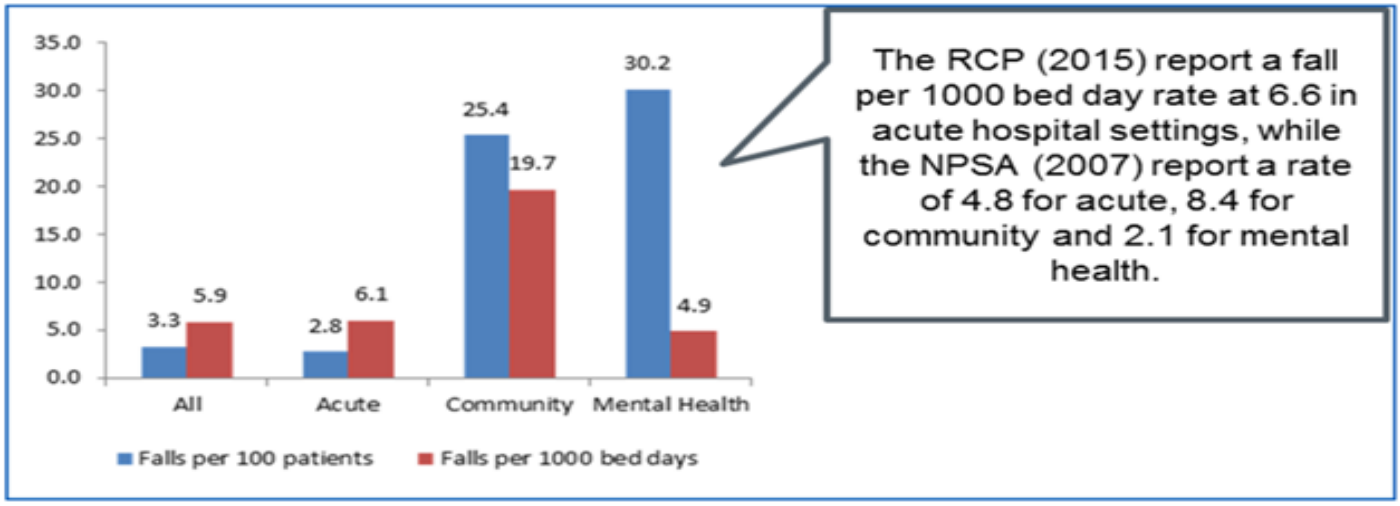
The clinical Executives continue to meet weekly to discuss current patient safety issues and emerging risks. A patient safety dashboard, as previously reported, is monitored to provide oversight of a number of quality indicators associated with the four harms of Covid as shown below. Key concerns include demand, patient acuity staffing and Covid-19.





Safe Care (Standard 2.3 – Falls Prevention)

Inpatient falls continue to be monitored on a weekly basis at the executive huddle and a rate of 5.02 per 1000 bed days was reported on 28 November 2021, which is some of the lowest reporting over many years. Falls continues to be RAG rated amber despite the rates as we maintain a focus on minimising injurious falls and embedding the revised policy. Our rate compares to a national rate of 6.6 falls per 1000 bed days in the acute setting and 4.9 in the mental health setting (RCP 2015). As the Committee are aware all falls resulting in fractures are presented at the Falls Review Panel to support learning, with injurious falls, to include those with head injury are reported weekly at the Executive Safety Huddle.



Safe Care (Standard 2.4 – Infection Prevention and Control)

Infection Control remains red RAG-rated, particularly associated with the acquisition of Clostridium Difficile. There is an improving picture, with positive performance when comparing ABUHB with other Health Boards in Wales against the nationally reported infections. If the rate of Clostridium continues to decline the RAG rating may reduce for the next reporting period.

International Infection Prevention Week

International Infection Prevention Week took place in October 2021**,** highlighting the science behind infection prevention. This event takes place around the world to demonstrate how we can protect health by reducing infection. This year's theme was "Make Your Intention Infection Prevention".

In addition to dealing with a global pandemic, infection prevention and control teams operate to protect from surges in healthcare-associated infections. To support the international campaign the Health Boards Infection Prevention and Control Team (IPCT) promoted a virtual winter campaign. Key messages in regards best practise to reduce health care associated infections were delivered by the Director of Nursing, Medical Director, Lead Antimicrobial Pharmacist, Head of IPCT and Lead Consultant for Infection Prevention.

Influenza

If influenza returns to usual seasonal activity this winter, the Health Board would expect to see an increase in cases during December. If influenza activity is similar to 2020-21, there is an expectation for case numbers to remain generally low throughout the winter period.

To date the Health Board is currently seeing very little flu activity. A typical flu season sees sporadic cases from early autumn, and indicators to suggest flu is widely circulating in Wales are usually reached in mid to late December.

Six cases of influenza have been detected in the Health Board since April 2021, all of which were detected on admission to assessment units and emergency department.

At the end of the 2020/21 staff flu immunisation season, ABUHB vaccinated 9190 of staff (66.4%). The Welsh Health Circular 2021-019 sets out an ambition to achieve a minimum of 80% staff flu vaccine uptake and a vaccination offer of 100% for the current 2021/22 season. To achieve the ambitious 2021/22 target, ABUHB started the season with a hybrid model to deliver the staff flu vaccination programme. Between 29th September and 1st October 2021, 3,500 staff members received a flu vaccine alongside their Covid-19 booster vaccine through the Mass Vaccination Centres. From 4th October 2021, the embedded peer vaccination model incorporating "Flu Champions" and Occupational Health Clinics has been implemented.

Uptake of the flu vaccine within ABUHB is less in comparison to last year and this pattern is evident within Health Boards across Wales. Week 8 of this season within ABUHB indicates an uptake of 47.4%, compared to the same week in 2020/21 where uptake was 54.7%. A series of action have been strategized, including the increase in communications, analysis of the reasons why staff are declining the vaccine and increased opportunity for vaccine offer. The programme has been without a project manager, which is believed to have had an impact. The post has now been filled. Vaccination rates are monitored and reported weekly.

Respiratory Syncytia Virus (RSV)

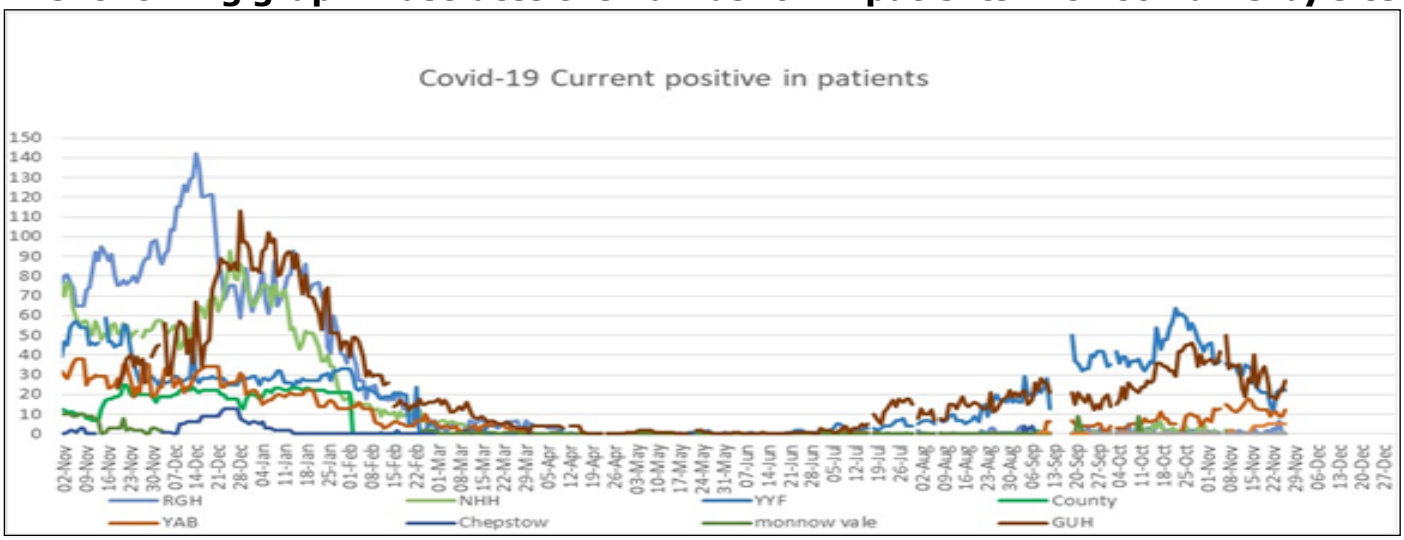
RSV is a seasonal respiratory virus which circulates in late summer through early autumn. In most adults RSV does not typically cause acute disease, however it can be severe in infants and children aged 5 and under. A surge has been predicted for 2021 with out of season infection expected during the Winter.

So far greater number of individuals have tested positive for RSV in ABUHB 2021-22, compared to previous years. This increase is a direct result of testing all hospital admissions to detect the virus early and rule out other respiratory pathogens. The intention of increased testing supports improved management of the virus, such as earlier antiviral prescribing and correct patient placement.

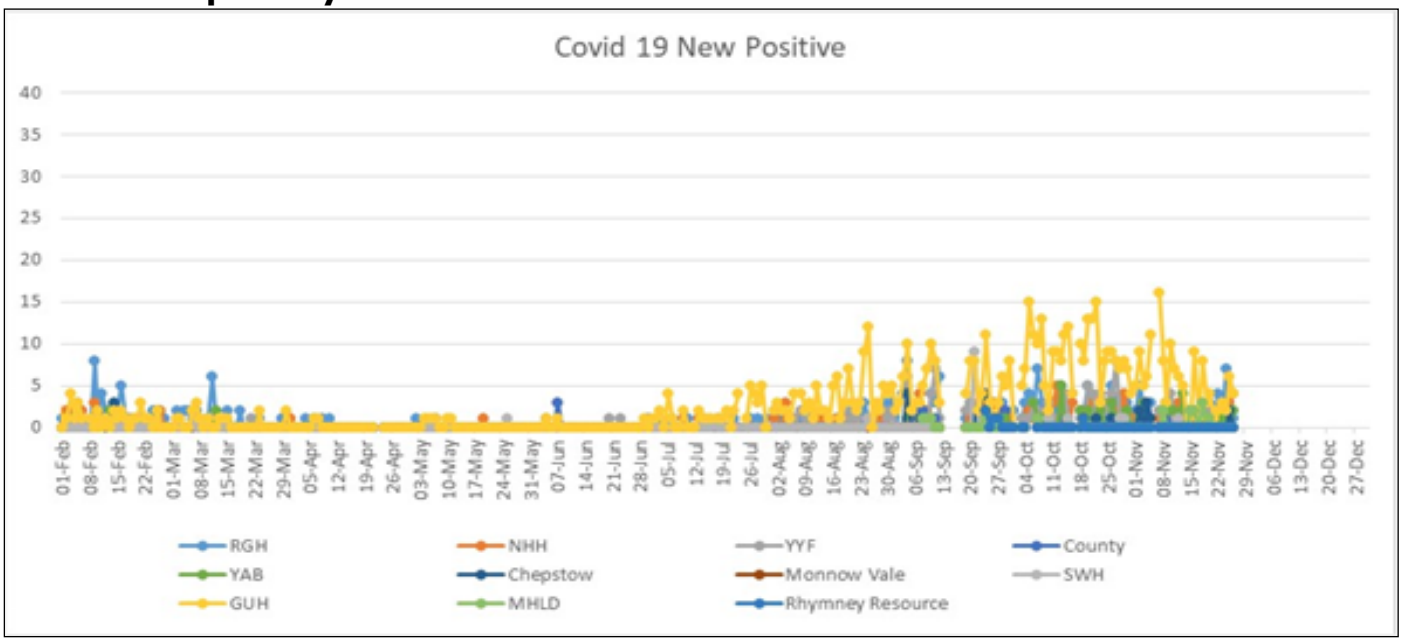
Covid-19

Throughout the month of October, the number of patients presenting with Covid -19 has followed a similar pattern to the previous month. Patients continue to be cared for within the existing red pathways at our single room hospitals, minimising the risk of onward hospital transmission.

The following graph illustrates the number of in-patients with Covid-19 by site

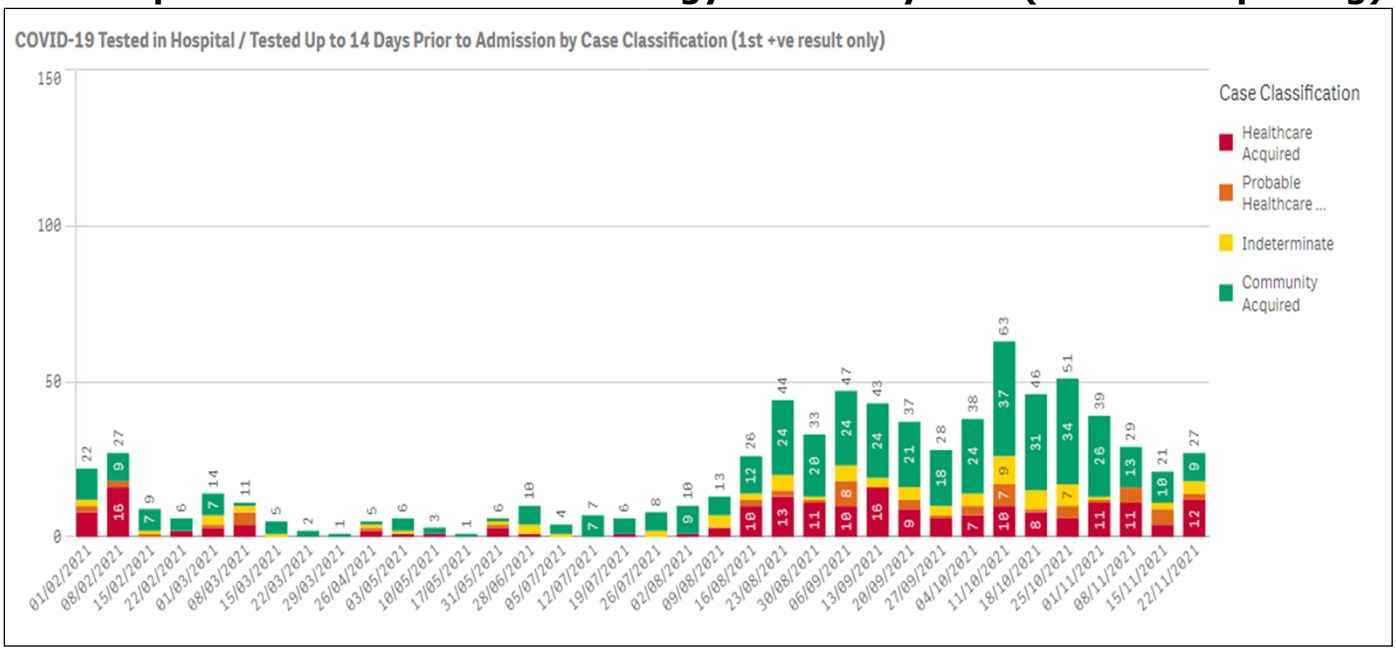


The following graph shows the number of new positive patients, ranging from 8-28 cases per day



There continues to be some variation in hospital acquired Covid infections because of patients testing as "low level positive". Following assessment by the microbiologist it has been determined these results are not because of a new infection. The potential reason for this is contamination or previous infection. This concern has been escalated to Public Health Wales; the Health Board is still awaiting a response as to how this will be aligned and rectified. The below graph demonstrates the external reporting for Covid-19, to include defining whether cases are health care acquired.

Cases reported direct from Microbiology laboratory feed (external reporting)

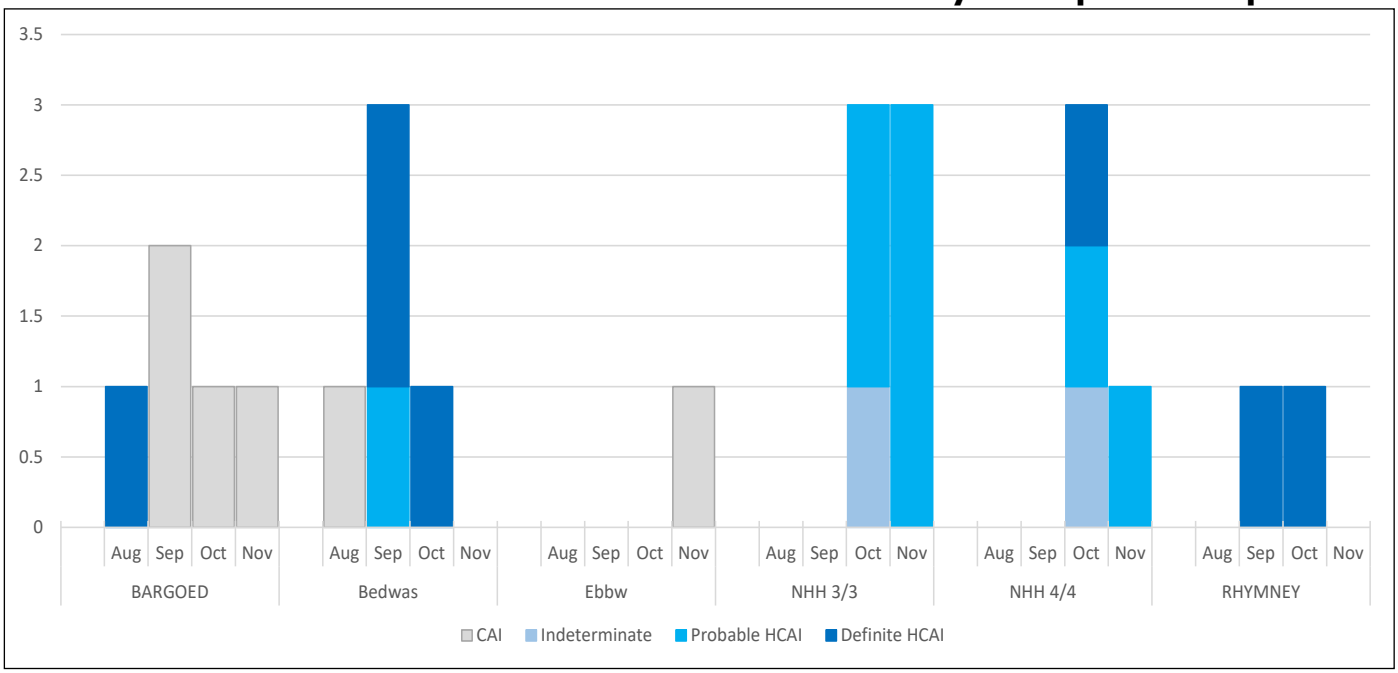


Covid-19 Outbreaks continue to be identified via the five-day PCR inpatient testing process. To detect Covid-19 at the earliest possible stage it is essential to ensure this process is adhered to, as patients are so often asymptomatic. For Quarter 3 the Health Board has declared 5 ward outbreaks associated with Covid-19.

- NHH Ward 3/3
- NHH Ward 4/4
- Rhymney Resource Centre
- Chepstow – Cas Gwent
- A4 - GUH

To note at the end of November an outbreak was declared in GUH. This is the first time an outbreak has been declared in the new hospital. RCA has deemed the outbreak is associated with an asymptomatic patient identified through routine testing. All outbreaks are reported to Welsh Government and are subject to robust MDT review, supported by Public Health Wales.

The following graph shows the monthly totals of Covid-19 cases linked to an outbreak ward with an associated death within 28 days of a positive specimen



A total of 15 mortality reviews have been undertaken in Quarter 3 utilising the national audit tool for probable and definite healthcare associated infection. The learning from each mortality review and outbreak control meeting is shared with the Division and the learning presented at the Reducing Nosocomial Transmission Group.

Care Home Data

A number of care homes are either in Covid incident or under review across the community of ABUHB. The community IPC team have continued to support care homes in incident mode, undertaking visits, audit and providing feedback to care home managers and the Local Incident Management Team. To date the IPC team have undertaken 102 care home visits since April 2021. The below graph shows a snapshot of daily reporting.

Care Home status Report

Local Authority	Status	No of Staff affected	No of residents affected
Blaenau Gwent	Incident = 4	12	0
	Under Review = 2	1	1

Local Authority	Status	No of Staff affected	No of residents affected
Caerphilly	Incident = 10	49	29
	Under Review = 4	4	0
Monmouthshire	Incident = 3	26	13
	Under Review = 5	4	1
Newport	Incident = 9	59	22
	Under Review = 1	2	
Torfaen	Incident = 7	34	36
	Under Review = 5	6	0

Health Board Comparison

The below tables provides an overall comparison for Health Boards across Wales against the infections for which there is a Welsh Government reduction target. ABUHB has the lowest rates in Wales for four of the six reporting areas. Further detail for each infection is provided.

Health Board	C diff per 100,000 population Target 25, per 100,000	MRSA per 100,000 population Zero tolerance	Staph A per 100,000 population Target 20, per 100,000	Gram Negatives E coli per 100,000 population Target 63, per 100,000	Klebsiella per 100,000 population Reduction 10%	Pseudomonas per 100,000 population Reduction 10%
ABUHB	**36.21**	**0.29**	**20.53**	**61.59**	**17.39**	**5.70**
BCUHB	37.10	1.21	24.73	64.99	20.85	5.82
C&VUHB	33.47	2.03	21.98	63.56	23.33	6.42
CTMUHB	33.37	0.38	26.16	95.55	17.82	8.34
HDUHB	42.01	4.38	31.07	97.60	19.26	10.07
SBUHB	52.79	3.49	37.08	82.02	27.05	4.80

Clostridium difficile (C diff)

There have been a total of 127 cases of C diff reported from April-October 2021. Although rates of C diff remain a concern, there is an improved picture since the last reporting period from 38.1 to 36.21 per 100,000 population. A total of 13 cases were identified in October 2021 (a reduction since the peak in June), all of which were sporadic cases, one outbreak has been identified in November 2021 on Bedwas Ward, Ysbyty Ystrad Fawr.

Breakdown of cases by division

C diff cases per month			Apr	May	Jun	Jul	Aug	Sept	Oct
Scheduled			1	3	1	1	4	1	1
Unscheduled			3	5	14	7	4	6	5
F&T			0	0	0	1	0	0	0
Community Hospitals			1	1	3	6	2	2	1
MH & LD			0	0	0	0	0	0	0
Primary and community acquired inc any relapses			3	4	14	3	10	2	4
inpt Relapses/ Indeterminate / Others			2	0	1	3	4	2	2
Total Cases			**10**	**13**	**33**	**21**	**24**	**13**	**13**

All incidents undergo a root cause analysis to determine cause and learning. Of the six community acquired cases, antibiotic prescribing was considered outside of guidance in 2 of the identified cases. Of the seven-hospital acquired C diff infections, two patients received antibiotics outside of guidance and a further two received potentially suboptimal antibiotics.

A focused approach to reduce C diff rates has been implemented, ensuring Divisional and professional engagement by way of challenge and support sessions. Meetings have been convened with Unscheduled Care and Community and Primary Care focused on C diff and the actions required to meet the Welsh Government Reduction Expectation Targets. Each Division has produced an improvement plan. To provide assurance this will be monitored via the reducing nosocomial transmission group (RNTG).

An additional measure to reduce the risk of C diff is to undertake a proactive Hydrogen Peroxide Vapour (HPV) deep clean. This has now been completed across the Health Board, with the exception of the Grange University Hospital where the ongoing rolling programme continues. The Committee will be aware of the previous delays to the proactive programme due to demand and capacity pressures.

To note, the clusters reported previously have now been confirmed as the same genotype, meaning confirmed nosocomial spread.

Antimicrobial Update

- Primary care data to Q1 2021/22 demonstrate ABUHB is tracking just below the Welsh national average in terms of antimicrobial volume, which remains significantly lower than pre-COVID-19 usage. Use of higher-risk antibiotics in primary care remains the lowest in Wales.

- Antimicrobial pharmacist has attended the Primary Care Clinical Directors Meeting to discuss the quality elements of the Welsh Health Circular, namely coding of infections and referral of dental presentations to General Dental Services and will be discussed further at Neighborhood Care Network (NCN) leads in due course.

- Recent secondary care data is still not available from Public Health Wales. Local data demonstrate an increasing trend in co-trimoxazole and co-amoxiclav use that will be monitored closely going into winter. Co-amoxiclav use remains significantly lower than pre-pandemic given the guideline changes implemented just prior to the pandemic.

- Uptake of the Start Smart Then Focus audit tool continues to be well supported on the YYF site where data has been collected as part of the Antibiotic Review Kit (ARK) project roll out. To improve compliance across all sites, the site-based leadership teams have been requested to feedback completion at RNTG. Completion of these audits will be a requirement of the 2022-23 Welsh Health Circular, as targets will be set during this period.

Staphylococcus Aureus Bacteraemia

A total of 73 cases of staph aureus haven been identified between April 2021 – October 2021. Twelve cases identified for the month of October equating to a HB rate of 20.81 per 100,000 population, which is the lowest rate in Wales. The majority of patients

were identified on admission to secondary care, eight patients presenting with sepsis on admission and four patients identified forty-eight hours post admission.

In October 2021 the HB identified the first case of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia since April 2021, the patient was identified as known carrier of MRSA.

A root cause analysis has been undertaken for each case, the source of infection is predominantly respiratory and urine.

Gram Negative bacteraemia

October saw a general increase in the number of patients presenting with gram negative blood cultures. A total of 54 cases have been reported across the HB resulting in a rate of 84.68 per 100,000 population, again the lowest rate in Wales for this pathogen.

Escherichia coli (E coli)

A total of 216 cases of E coli bacteraemia were identified between April–October 2021. 36 identified for the month of October 2021 of which 26 were Community acquired and eleven patients identified post admission. The E coli rate for the HB is 61.59 per 100,000 population, the most common source being urinary tract infection and is the lowest rate in Wales.

To reduce E coli bacteraemia a Bladder Focus and Trial Without Catheter (TWOC) initiative is being progressed by the Health Boards Bladder and Bowel Service to reduce harm from indwelling catheters, reduce infection and avoid hospital admission.

Klebsiella

A total of eleven cases identified within October equating to a HB rate of 17.09 per 100,000 population. All of which were sporadic cases, no clusters identified. This pathogen is often linked to antimicrobial resistance where patients have received ongoing treatment for their complex health needs. ABUHB has the lowest rate in Wales.

Pseudomonas

A total of four cases identified equating to a HB rate of 5.70 per 100,000 of which three patients were identified on admission and recorded as community acquired. This is the second lowest rate in Wales.

Decontamination

In accordance with Welsh Health Technical Memorandum required standards, continuous improvement within decontamination remains paramount within the Health Board decontamination strategy. The lead nurse has been working collaboratively on the following projects.

- The Royal Gwent Hospital centralised decontamination unit plans continue with agreement by stakeholders, the location being the existing endoscopy unit on floor 3 and final plans have been drafted.

- Ears Nose and Throat (ENT) units at NHH, YYF & RGH will have and decontamination areas upgraded with Ultra Violet (UV) machine to aid the decontamination of scopes

- The Royal Gwent Hospital new endoscopy unit build stage 4 plans are in the process of being finalised.

- The pilot for Community Dentistry Service (CDS) Hospital Sterilisation Decontamination Units (HSDU) decontamination has commenced from the Abertillery clinic. Review of the pilot will assist in future development of CDS decontamination across the Health Board.

- CDS WHTM 01-05 audits continue to be undertaken and feedback to CDS Health and Safety meeting for noting and action.

Safeguarding (Standard 2.7 – Safeguarding Children & Adults at Risk)

A stand-alone safeguarding highlight report is being presented to the Committee for information. To note, there is concern regarding the compliance to safeguarding training for children which has been added to the Safeguarding Risk Register, with actions being taken to secure improvement.

Dignified Care

The principle of dignified care is that the population are treated with dignity and respect and treat others the same. Fundamental human rights to dignity, privacy and informed choice must be protected at all times, and the care provided must take account of the individual's needs, abilities and wishes.

Meaningful Activity (Standard 4.1 Dignified Care)

There is clear evidence that meaningful activity helps alleviate behavioural and psychological symptoms of dementia by enhancing overall quality of life through engagement, enhanced social interaction, and opportunities for self–expression and self-determination (Han, et al. 2016). A Proof of Concept (PoC) and Service Evaluation commenced at Ysbyty Aneurin Bevan (YAB) on the 1st July 2021. The initiative was extended, as initially it was intended to conduct an evaluation in September and present findings in October but demand and capacity pressures and staffing challenges have hampered the project.

Through locally agreed outcome measures, the PoC and Service Evaluation aimed to verify the vision that meaningful activity, dementia training for staff and the creation of Dementia Companion Volunteers would collectively improve overall quality of care, patient safety, patient experience and support transferability.

The pandemic and restricted visiting have negatively impacted on patient experience. Patients have expressed feelings of loneliness and boredom, due to a lack of meaningful activity. Across our hospitals, the number of patients requiring enhanced supervision has increased. Enhanced supervision involves close monitoring of emotional, physical and mental well-being. However, close supervision can, in itself, be restrictive. The PoC aimed to raise awareness of person centred dementia care and the benefits of

meaningful activity to both reduce restrictive practice and improve patient wellbeing. In preparation:

- Multi-disciplinary Steering Group established and outcome measures agreed.
- Dementia Companion Volunteer role profile developed.
- Kings Fund baseline Environmental Audit undertaken on each ward.
- Independent observational visit by the Community Health Council (CHC).
- Charitable funds enabled resources to support meaningful activities.
- Programme of Dementia Companion/staff training developed and delivered.
- Dementia Champion framework agreed.
- ICF funding secured to employ Dementia Practice Educators (to March 2022).

An evaluation of the PoC has secured improvements in practice at YAB illustrating the benefits that meaningful activity, staff training and the introduction of Dementia Companions can have in supporting patients who require an enhanced level of care.

In terms of staff training: from a baseline of 30%, staff compliance with online all Wales mandatory dementia awareness has increased to 60%. Staff surveys/reflective conversations illustrate the positive benefits to both patients and staff of training and engaging people in meaningful activities. An increased number of staff are now more confident and skilled to engage with patients when undertaking 1:1 observation. 2 bespoke training programmes for staff and volunteers were developed and E-Rostering improved attendance. From a baseline of 0%, 17 staff have received dementia and meaningful activity training. Training included dementia awareness, meaningful activities, behaviours that challenge, 3Ds (Dementia, Depression, Delirium). The GURT (age simulation suit) provided staff with experiential learning. Staff and volunteers evaluated the training as excellent, increasing their confidence to care for a person with dementia. In terms of the Dementia Companions, the introduction of Dementia Companions has received a very positive response from staff and patients. 8 Dementia Companions have been recruited and trained to date. Due to COVID-19 risk assessments, 2 volunteers are currently active on Tyleri and Ebbw wards. For those patients who the Companions have supported, benefits include increased interaction, diversion to reduce behaviours that challenge, improved mood and reduced boredom.

One of the Consultants has said: "*The support that the dementia volunteers have provided on the ward has been invaluable especially in supporting patients with dementia/delirium and in meaningful activities and around meal times. The volunteers have built a good rapport with staff and patients alike and will always come to ask who the priority patients to see are. We speak about the patient's journey and what we are trying to achieve through their support. They are very kind and enthusiastic and have a real passion in trying to make a difference in these patients' lives, something that everyone who works in the NHS shares, so they truly are part of the team. I hope that this continues and am keen to give further support moving forward".*

Throughout the PoC closer MDT working relationships has seen the reinstating of the Food Interest Group, allocation of a Nutrition Support Worker, the development of a Referral Data Tool, improved communication with relatives and co-ordinated visiting all demonstrating the proof of concept has been successful.

This model is transferable to other ward areas but requires investment in terms of staff training and learning, promotion of ward-based Dementia Champions, recruitment, training and support of volunteers, and meaningful activity resource.

To support a phased approach to roll out, recommendations have been identified which will be presented to the Executive Team for consideration and include:

1. Working with Divisional Teams to identify priority areas in which to roll out the model.
2. Based on priority areas, a rolling programme of training takes place through to March 2022 in readiness for the launch of the All Wales Dementia Hospital Charter (anticipated Spring 2022).
3. Further recruitment of Dementia Companions.
4. Ongoing recruitment, training and networking support to increase ward based Dementia Champions.
5. Bedside Patient Boards to include the daisy symbol so that staff can 'at a glance' identify a patient with dementia.
6. Additional meaningful activities are resourced (bid has been submitted).
7. Evaluation of the use of coloured walking frames in falls prevention.
8. 'Facebook Live' event to be held in the New Year to inform the public of the Hospital Charter, benefits of meaningful activity and promotion of 'This is Me'.
9. The In-Patient Dementia Hospital Group maintain oversight of the roll out.

Individual Care

The principle of individual care is that people are treated as individuals, reflecting their own needs and responsibilities. All those who provide care have a responsibility to ensure that whatever care they are providing includes attention to basic human rights. Where people are unable to ensure these rights for themselves, when they are unable to express their needs and wishes as a result of a sensory impairment, a mental health problem, learning disability, communication difficulty or any other reason, access to independent advocacy services must be provided. Every person has unique needs and wishes. Individual needs and wishes vary with factors such as age, gender culture, religion and personal circumstances, and individual needs change over time, respecting people as individuals is an integral part of all care.

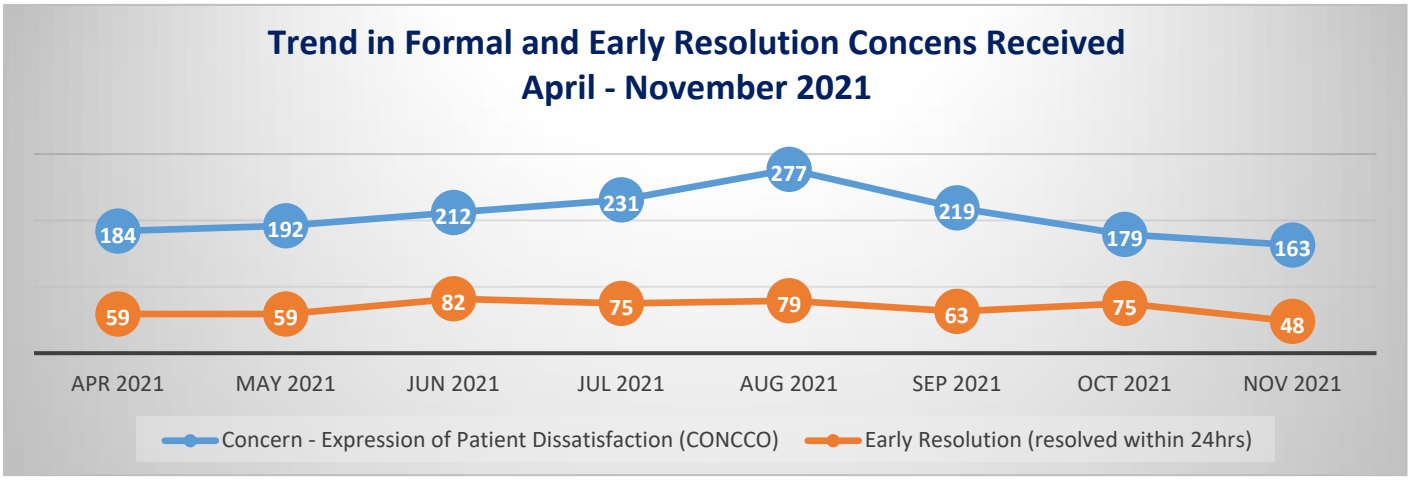
Complaints/Concerns and Serious Incidents (Standard 6.3 Listening and Learning from Feedback)

The 'Once for Wales' Feedback Module went live on the 1 October 2021. Once embedded it will bring consistency to the use of the electronic tools used by all NHS health bodies. It will provide an integrated functionality to support a range of essential patient safety and experience functions. We are currently unable to provide Divisional and Health Board performance for October and November 2021. This issue is being worked through with the national team and retrospective data will be provided once available.

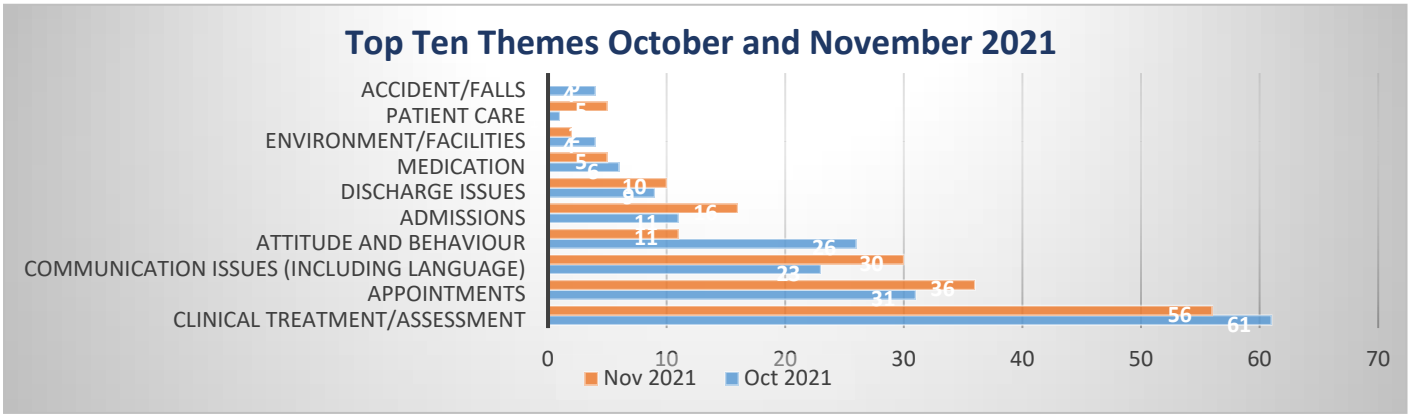
A test of change is proposed for the effective but proportionate management of complaints through the winter period, utilising the local options framework. It is

recognised that through the winter it will be challenging for clinical teams within Divisions to focus on complaint management within turnaround times likely to be impacted, and consequent dissatisfaction amongst people who complain. Feedback regarding impact will be provided to the PQSOC.

The number of formal complaints received during October and November was 342. During the same reporting period in 2020, 294 were received, this equates to an increase of 16%. As illustrated in the graph below, even though there is a downward trajectory in relation to the number of formal concerns received, this remains an increase on 2020.



There is slight variation in subjects within the new system. The top 10 reported themes are illustrated below:



The top three themes are;

1. Clinical treatment /Assessment
2. Appointments
3. Communication Issues (Including Language)

Work is ongoing to improve communication as reported previously, with positive updates to report in relation to the Patient Liaison Service, which include;

- One PLO in place currently working 3 days per week 12 hour days fielding all calls from 08.00am – 20.00pm. Interviews for a further two posts are scheduled for the week of 6th December through an agency in order to try and expedite recruitment. If successful they should be in post prior to Christmas.
- Additionally, a bid has been prepared for a Patient Advice and Liaison Service, for Executive consideration.

Public Services Ombudsman for Wales (PSOW)
At the end of November 2021, there were a total of 46 open PSOW cases at various stages within the process.

This included 16 new cases received during October and November 2021. Of these, 6 were full investigations and 5 were settlement proposals. The settlement proposals during this period involved redress payments totalling £375, with redress payments being primarily for shortcomings in the complaint handling process. The remaining were cases where the PSOW had decided not to investigate, or where the Health Board had not yet provided a response; these cases went back to local resolution.

The Health Board has also recently responded the PSOW Annual Letter which has been included for information.

Patient Safety Incidents (Standard 6.3 Listening and Learning from Feedback)

The revised national reporting framework requires that patient safety incidents will be reported if it is assessed or suspected an action or inaction in the course of a service user's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their unexpected or avoidable death, or caused or contributed to severe harm.

The following table provides quantitative data in relation to incidents, including those reported nationally.

2021	All SIs	Reported to the DU	Early Warning Notification	Never Events	Red 1	Red 2
October	15	1	5	0	1	14
November	24	2	6	2	2	22

The three incidents reported in October and November related to;
1. An unexpected death
2. Two Never Events 1 relates to the retention of a pin
   1 related to wrong route medication

Improvements relating to the T&O never event include:
- WHO checklist updated throughout all sites to ensure most recent version is used.
- Checklist now includes visual inspection of equipment pre and post procedure

The Wrong route medication incident is currently under investigation.

To note, an anonymous concern has been raised with HIW regarding incidents in Theatres. A response from the Health Board has been provided.

There is a joint tabletop review between ABUHB and WAST planned for early December to discuss several cases relating to inappropriate WAST conveyance of patients and self-presenting patients to eLGHs.

There has been a month on month increase in 'Early Warning Notifications' (previously known as a 'No Surprise') sent to Welsh Government. The purpose of these notifications is to ensure timely communication of incidents that could potentially attract Media attention. The majority of such notifications concern PRUDiCs as this is now the pathway for such incidents rather than reporting as a Nationally Reportable incident.

The Corporate Team currently have 37 open investigations including 1 PRUDiC, in comparison to November 2020 when there were 127 open including 11 PRUDiCs. To contextualise the majority of PRUDiC investigations are managed via this process and are not investigated as serious incidents.

The Corporate PTR Team have been under significant pressure with 8 staff absent from work, some long term. This has impacted on the teams' ability to support Divisions and provide the due diligence required for the management of concerns.

External Inspections and Peer Review - internal and external inspections
(Standard 6.3 – listening and learning from feedback)

A standalone paper is being presented to PQSOC which details recent inspections undertaken by Healthcare Inspectorate Wales and the Community Health Council (CHC).

In addition, the CHC undertook a virtual engagement project with inpatients mental health wards in the summer to understand more about their experiences. The report recounts what CHC heard about the experiences of the patients and includes:

- Temperature control on one ward
- Appropriate bedding availability
- Provision of support for patients when attending meetings
- Meaningful activity
- Opportunities for voluntary work and education
- Accessibility of medical teams
- Signage

The Health Board have provided a response and have produced an action plan to address the recommendations.

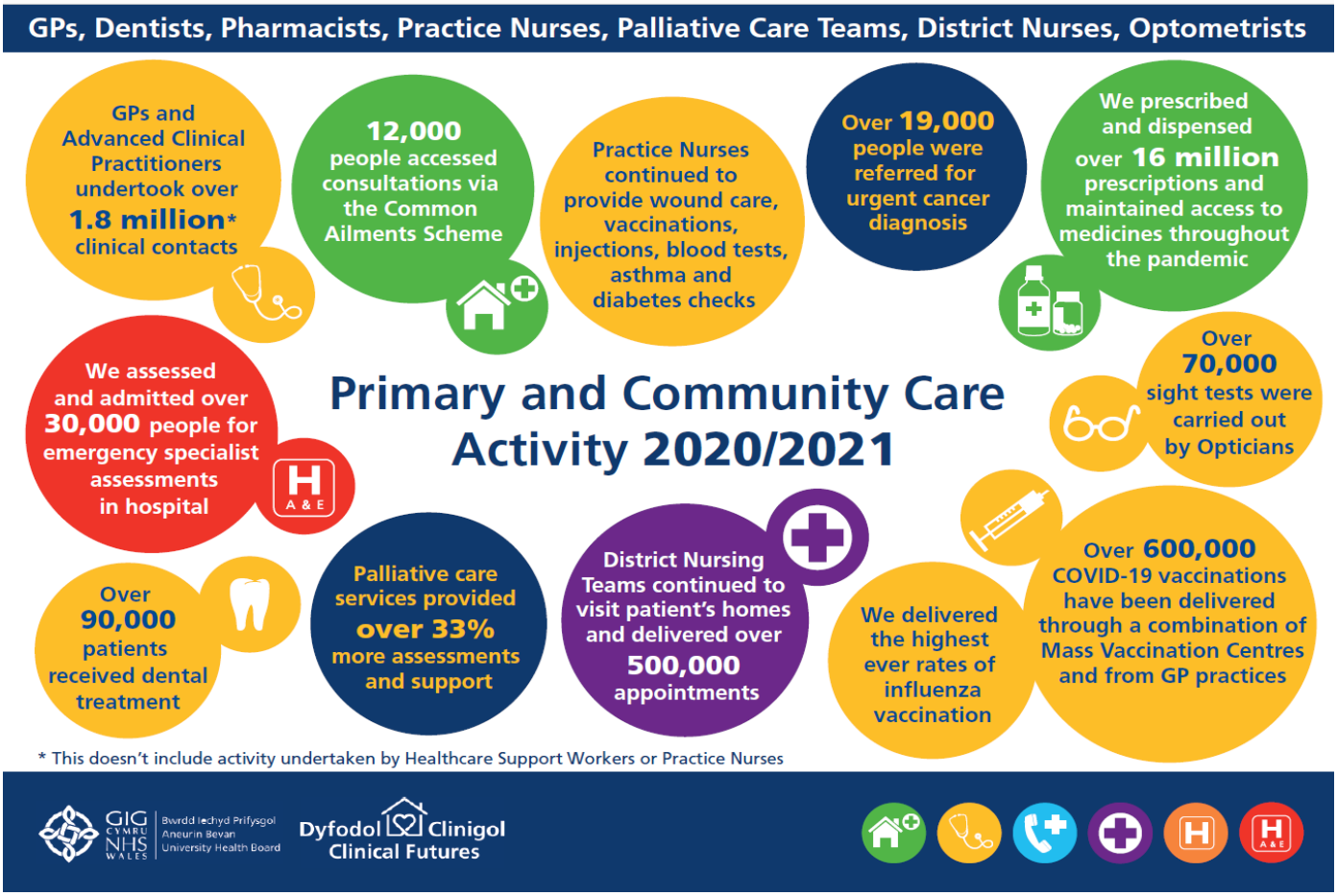
HIW also undertook an inspection within the Radiology Directorate in GUH on 16th and 17th November, no concerns with compliance with radiation legislation were noted and no immediate assurance were issued. A formal response from HIW is pending.

Timely Care

The principle of timely care is that people have timely access to services based on clinical need and are actively involved in decisions about their care. Not receiving timely care can have a huge impact on individuals' experience of health services and their ability to achieve the best health outcomes. To ensure the best possible outcome people's conditions should be diagnosed promptly and treated according to clinical need.

Access to primary care (Standard 5.1- Timely Access)

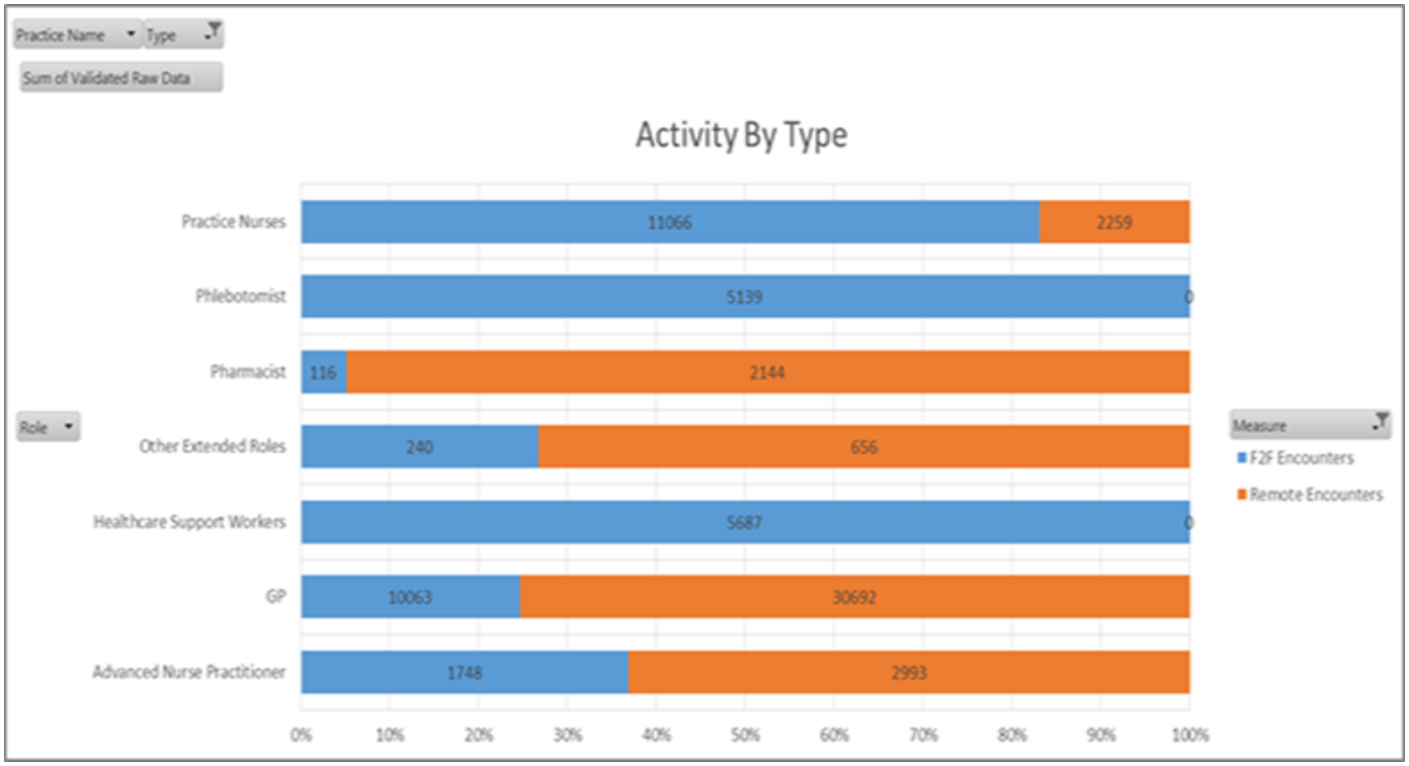
The infographic below illustrates a range of primary care activity, showing diversity and scope.



The Health Board is responsible for providing General Medical Services (GMS) to residents throughout Aneurin Bevan University Health Board and commissions services from independent contractors through The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004. Approximately 90% of all patient interventions take place in the primary care setting. General Practice is reporting unprecedented demand, up to 20% more from pre- COVID rates, as are other parts of the healthcare system, and we need to support and facilitate service delivery to ensure safe and effective care continues to be provided to patients. An update has been provided on access, albeit RAG rated amber, as this is a concern expressed by the Community Health Council and Independent Members.

The traditional GP practice model was evolving prior to the pandemic, with practices following the principles of prudent health care and supporting multi-disciplinary care delivery. Prior to the pandemic, care navigation training was provided to GP receptionists across the Health Board. This is to ensure patients are directed to the most appropriate service and/ or clinician to meet their needs at that time. In order to do this they are trained to ask patients a series of questions regarding their need to call the practice.

Practices have adopted a blended approach to patient consultations, offering both face to face and remote consultations, as appropriate. The number of face to face appointments is increasing, however there are challenges with this, especially in relation to managing social distancing and throughput of patients. The findings of the access review indicated that across ABUHB, there was a split of 25% face to face and 75% remote consultations. The table below illustrates the split between Face to Face and virtual consultation by profession.



In the absence of a national standard, the Health Board has a locally agreed benchmark of 1 clinical session per week, per 200 registered patients. Practices with a shortfall of 15% or more have been identified as outliers. There are currently 16 practices with a shortfall of 15% or more (pending confirmation). However, approximately 58% of practices reported that they were meeting, or exceeding, the 1:200 clinical sessions. A review has demonstrated that in many cases, practices are meeting the 1:200 benchmark for clinical sessions and yet are still unable to meet demand. To further support practices to increase GMS clinical capacity, recognising the ongoing pressures that practices are currently facing, the Health Board has commissioned a new Local Enhanced Service (LES) to fund additional clinical sessions. This LES supports an additional clinical session per week, per practice where the practice already provides at least one clinical session per 200 registered patients weekly, determined by practice list size;

- 0-10,000 registered patients = 1 additional clinical session per week

- 10,001-20,000 registered patients = up to 2 additional clinical sessions per week.

The additional session(s) is required to be provided by either a GP or Extended Role with Independent Prescriber session and need to offer a minimum of 50% face to face appointments and a maximum of 50% remote appointments and should be available for pre-booking.

Further funding for additional clinical sessions has been agreed, on the same basis as the LES, under the Restart & Recovery scheme. This further funding will support one additional clinical session per 2,000 patients, and for those practices commissioned to provide the LES, this will be a 'top-up'.

General Dental Services (GDS)
Due to the current situation in relation to Covid-19, Welsh Government has issued very clear guidance to all NHS dental practices on the types of treatment that can be carried out during this time. NHS dental practices across Aneurin Bevan University Health Board continue to provide dental care in accordance with this guidance. Dental practices have been asked to delay routine dental checks for low risk patients so that they have appointment slots available for those who need urgent treatment or treatment that has been delayed.

GDS figures for 2021/22, as at end of Oct 2021

- Total number of patients seen
  - Total number of adults seen – 64,888
  - Total number of children seen – 25,029
- Total number of urgent patients seen – 22,436 (this is a combined figure for Adults and Children as urgent appointments are separated out)
- Total number of orthodontic claims processed – 1,000 case starts in total against a target of 1,574 case starts (63.50%).

Urgent and Emergency Care (Standard 5.1 – Timely Access)

This remains RAG rated red and is subject to a stand-alone report.

Stroke (Standard 5.1 – Timely Access)

Stroke remains a RAG rated red.

Over the course of 2021 since the opening of the Grange University Hospital (GUH), the Health Board's stroke services have been adversely affected on by the ongoing impact of the pandemic and the current significant urgent and emergency care demand and related pressures, especially with the acute and sub-acute part of the stroke pathway.

The Health Board reports on key performance metrics called Stroke Quality Improvement Measures and these are routinely reported into Welsh Government. 2021 performance data shows a declining position across a range of the Quality Improvement Measures. ABUHB is not unique in seeing its stroke performance deteriorate through the course of 2021, and with most of its quality metrics ABUHB compares well against other Health Boards. As with many of our Health Board services which are progressing

recovery plans, the stroke service is assessing the current situation and identifying opportunities and action to recover its performance. The stroke recovery action plan is being overseen by the Executive led Stroke Delivery Board and reports regularly to the Executive Team on progress. The list below is a summary of the key issues and related actions being progressed:

Concerns about early identification and timely onward referral of confirmed or query stroke patients arriving at the Emergency Department

This issue has become apparent following review of clinical incidents. The consequence is that stroke patients are not being admitted to the HASU in line with the required timeframe (target 4 hours) to achieve optimal care outcomes. There are also consequence for the Emergency Department becoming congested as patients are held in the department. Immediate action identified was to review and agree the stroke criteria and pathway that is applied in the Emergency department (now implemented). Longer term action will be to consider the opportunity for establishing a fast-track pathway to HASU, though this does rely on adequate medical cover out of hours within the HASU.

Concerns about stroke patients not having the immediate swallow screen in the Emergency Department as required, mainly due to the increased demands placed on the Emergency Department staff.

The consequence is that stroke patients are not having their swallow screen in line with the required timeframe (target 4 hours) to achieve optimal care outcomes. Immediate action identified is training the Emergency Department staff to be able to complete the Yale swallow screen (now implemented). This is likely to be more of a requirement out of hours where there is no stroke specialist nurse cover. Ensuring bed capacity and timely transfer to HASU would also avoid the need for Emergency Department staff to complete this as the HASU staff are able to perform if they are alerted to the patient within the timeframe.

Concerns about HASU capacity not being available when required and acute stroke patients being held in the Emergency Department

This capacity issue occurs for two main reasons: first when stroke patients are not transferred from HASU onto the acute and rehabilitation wards at the eLGHs and secondly when non-stroke patients are admitted into the HASU beds. The consequence is that stroke patients are not being admitted to the HASU in line with the required timeframe (target 4 hours) to achieve optimal care outcomes. There are also consequence for the Emergency Department becoming congested as patients are held in the department. In October 2021, only 19.3% of patients reached the Hyper Acute Stroke Unit (HASU) within 4 hours of arriving at hospital. Low compliance with this measure has direct negative impact on patient outcomes. Immediate action has been identified to protect the pathway capacity. The Stroke Directorate has agreed a Standard Operating Procedure (SOP) aimed at protecting stroke capacity on the HASU and acute/rehab sites. This SOP will need to be accepted and adopted by the GUH and eLGH site management teams. The stroke capacity needs to be reported on the routine hospital SITREPs with action identified to release capacity (as it is for ITU capacity). The SOP ensures that breaches to the stroke capacity must be agreed by the Executive on call and a rationale provided and monitored. Specific to HASU beds, to ensure the beds are ring fenced for stroke patients, general medical patients must never use the last two remaining beds on the ward. There should always be a minimum of two

remaining beds for presenting stroke patients. Adoption of the SOP to protect stroke bed capacity to be considered by the Executive Team in December 2021.

Loss of the HASU therapy room impacting on urgent therapy performance

The HASU at the GUH (Ward B4) has 15 beds plus 1 therapy room. The therapy room is an essential facility for a HASU and ensures timely therapy assessment in the immediate, acute phase of care; without this facility it will not be possible to meet the urgent therapy quality performance measures. With continued system pressures and demand for beds at GUH, this therapy room has been lost to accommodate a bed with the anticipated deterioration of therapy performance. Immediate action to resolve this is to reinstate and protect the HASU therapy room – protection of this space to be considered by the Executive Team in December 2021.

Medical workforce gaps

The Medical workforce remains a challenge for the stroke service. Workforce modelling completed in May 2020 demonstrated a requirement of an additional 2.1 wte consultants to support the GUH model i.e. supporting 4 Hospitals with acute patient care. Previously, Gwent patients would remain at the RGH HASU for at least 7 days until they had completed their acute phase and would then be transferred to St Woolos Hospital for rehabilitation. The rehabilitation ward at St Woolos was only staffed to provide a rehabilitation service. Other additionalities include providing a weekend TIA service, triaging daily TIA referrals and working on the stroke on call rota. The workforce has been further impacted as two senior staff members' (consultant stroke physician and associate specialist) retired in August and October 2020. The consultant post has been advertised three times without successful appointment and the Speciality Doctor replacement is still ongoing. The consultant job description is being rewritten to attract a wider pool of candidates. The Associate Specialist who retired was also working independently as a consultant and was part of the stroke consultant on call rota. COVID has further impacted the teams medical resources as two consultants (one on the rehabilitation site and one who provides a weekly stroke session) have been shielding and working on non-patient facing duties.

Stroke Nurse Recruitment

Two Band 6 Stroke Nurses have now started in post and are undertaking their Stroke Nurse training. This involves academic as well as practical training. The Band 7 Clinical Nurse Specialist has recently been successful securing a role with the Putting Things Right Team and will be leaving post shortly. The service plans are to backfill the B7 CNS with another Band 6 Stroke Nurse and all Stroke Nurses will then be managed by the Ward Sister on B4.

Stroke Co-ordinator Role to support the Clinical Nurse Specialist Team

Currently, all of the SSNAP data collection and entry at the HASU is inputted by the Clinical Nurse Specialist Team. This reduces the team's capacity. A Data Coordinator has now been recruited fixed term for 1 year and is starting post week commencing 6th December.

Therapy performance and workforce capacity

In July 2021, the Health Board commissioned an external review to analyse the current status of specialist therapy workforce for stroke services in ABUHB against recommended standards. This includes services to patients in commissioned stroke beds as well as those receiving specialist care from the Early Supported Discharge

(ESD) community service which in Aneurin Bevan University Health Board is via the Community Neuro-rehabilitation Service (CNRS). The purpose of the review was to update on the planning work undertaken in 2016 and identify any efficiencies or gaps in therapy workforce to ensure stroke services and therefore stroke survivors are assessed and treated by an adequately staffed workforce that are skilled and competent. The findings will now be used to further inform the Health Board's stroke recovery plan.

Mismatch between demand and capacity across the pathway

The stroke capacity at the HASU and eLGHs is planned on the basis of a set number of daily admissions and length of stay in each part of the pathway and discharges. This capacity was agreed and funded through the 2016 stroke redesign programme and business case. Since that time, demand for acute stroke care has increased, which has therefore impacted on the efficient flow throughout the pathway due to limited capacity. This adverse impact is further exacerbated due to loss of capacity due to decisions to accommodate non-stroke patients. This mismatch between demand and capacity directly impacts the service ability to provide timely stroke care in a dedicated acute or rehabilitation environment and by the expert team, with the predictable adverse impact on key quality outcomes and related performance indicators.

The Health Board's Stroke Delivery Board committed to undertake a review the 2016 model and configuration, with consideration of the most clinically effective pathway that can be achieved within the set resources. This has been described as 'Phase 2 Redesign' and would require a review of the configuration for acute and rehabilitation capacity on the eLGH sites along with the stroke teams dedicated to these sites. An evaluation of the 2016 bed numbers in light of expected and real admissions, length of stay and discharges will need to be considered. Opportunities around economies of scale with any configuration options should be looked at, with a view to maximise the limited resources available, in particular with therapy resources. The Phase 2 Redesign review work started in early 2020 supported by corporate planning, but was stalled by the pandemic and now needs to be restarted as part of the recovery work. An immediate action identified is to undertake a review of current demand and capacity, including length of stay, which colleagues in corporate planning have agreed to support.

GIRFT External Review

The service has engaged with an external company called "Getting it Right First Time" (GIRFT). The GIFRT team has successfully reviewed every Stroke Service in NHS England and is due to start working with the ABUHB Stroke team in the New Year. The plan will be for the GIRFT Stroke Specialists to firstly hold a summit with the Stroke team to provide an opportunity for the Stroke Team to voice their ideas to improve the workforce model and will also showcase previous work that the GIRFT has been involved in to improve stroke services. Following the summit, the GIRFT will review the stroke service from point of contact through to discharge and post discharge care, to recommend areas for improvement. The GIRFT review will be helpful to further inform and refine the Health Board's stroke recovery action plan described in this paper.

Recommendation

The Patient Quality, Safety and Outcomes Committee is asked to:

- **Note** the Health Board position against a range of key quality and safety metrics, notably Urgent and Emergency Care, Stroke and Infection Control which are red RAG-rated.

- **Discuss** performance, themes and actions.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report reviews high level data in order to highlight clinical risks in the system. The quality improvement initiatives in this report are being undertaken to improve patient safety and therefore reduce the risk of harm to our Patients. Improved patient safety also reduced the risk of litigation Issues are part of Divisional risk registers where they are seen as a particular risk for the Division and a number of areas are also included within the Covid and Corporate Risk Registers.
Financial Assessment, including Value for Money	Some issues highlighted within the report will require additional resources to support further improvement. These will be subject to individual business cases which will contain the full financial assessment. In many cases, improving the quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.
Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	As an assurance report, this paper does not require an impact assessment.
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*

	Long Term – Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement –Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	See section 4.
Public Interest	Report has been written for the public domain.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Day, Date, Month, Year Agenda Item: XX

Aneurin Bevan University Health Board

WCCIS – Welsh Community Care Information System

Executive Summary

Due to national system performance and stability issues following a national platform upgrade, the ABUHB planned implementation for Mental Health & Learning Disabilities (MH&LD) Services in November 2021 was postponed. The postponement exposes the Health Board to increased risk due to the current technical support contract for ePEX coming to an end on 31st March 2022.

An options paper was shared with the local WCCIS programme board for discussion and direction and an update against each option, to mitigate the risk of ePEX becoming unsupported, was presented to the local programme board meeting on 9th December 2021.

The options investigated included an upgrade of ePEX to EMIS Web, re-planning of WCCIS Version 5 and a move to Version 6 of WCCIS. Options also included seeking alternative solutions however due to timescales, the procurement and implementation of a new solution at this stage is not feasible.

At a programme board meeting on 9th December 2021, the following next steps and recommendations were agreed:

- Pursue discussions with EMIS urgently to establish extended support arrangements for a minimum of 3 months post March 2022 – Meeting scheduled W/c 13/12/21
- Establish a March 2022 go-live window with national programme team and supplier
    - Conduct detailed re-planning of go-live including training arrangements and undertake risk review to gain support of live organisations for ABUHB on-boarding
- Continue to explore any other feasible alternative options and refine associated implementation timelines

A further programme board meeting is scheduled for 17th December to review progress.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	

Note the Report for Information Only			
Executive Sponsor: Nicola Prygodzicz			
Report Author: Janice Jenkins – Assistant Director of Informatics Programmes			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 10th December 2021			
Supplementary Papers Attached: Appendix 1 – Risk Profile Assessment			

Purpose of the Report

The purpose of the report is to provide the PQSO Committee with an update on the risk exposure for the Health Board due to the postponement of the implementation of WCCIS for MH&LD services.

Background and Context

The Welsh Government has endorsed a strategy of closer working between Health and Social Care services and the desire to support more citizens at home. The ambition is to provide high quality, people-focused, local, integrated care; to ensure the whole system is safe and effective, with people receiving the right care, at the right time, in the right place, from the right person. Underpinning this approach is the expectation that ICT solutions will need to be delivered. The Welsh Community Care Information System (WCCIS) has been nationally procured to support the transformation of community, social care, mental health and therapy services across Wales.

Phase 1 of the WCCIS programme was due to go LIVE in July 2019, which involved an implementation across all Mental Health & Learning Disabilities (MH & LD) services. A delay notice was issued by the WCCIS supplier in February 2019 based on issues with the supplier not being able to deliver the ABUHB required functionality, including critical integration. The local Programme Board took the decision not to go LIVE with significantly reduced functionality and re-planning has been underway to ensure the implementation of WCCIS achieves the benefits outlined in the business case.

In October 2020, a Wales Audit Office report was published following an audit of the national programme and implementation progress. It was found that the implementation and roll-out of WCCIS across Wales is taking much longer and proving more costly than expected and that despite efforts to accelerate the process, the prospects for full national take-up, across 29 organisations, and benefits realisation remain uncertain.

An internal audit of the arrangements in place for the management and control of the ABUHB WCCIS programme was also undertaken and published in October 2020. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with WCCIS was given as substantial.

A revised plan was developed in conjunction with the national programme team and supplier and a new go LIVE date in November 2021 was targeted for MH&LD services. Unfortunately, due to national system performance and stability issues following a CRM platform upgrade carried out in October 2021, the ABUHB planned implementation in

November 2021 was postponed following a request from the National Programme and local authorities.

The Committee is asked to acknowledge that a risk remains from a Quality Patient Safety perspective that the EPEX system which was due to be unsupported from the end of December 2021, has now been extended to March 2022. However, the system remains fragile and in the absence of an alternative system by March 2022; a residual patient safety risk that WCCIS cannot be relied upon given current performance issues, remains. An assessment of the risk profile is included at ***Appendix 1*** of this report for reference and information.

An options paper was shared with the local programme board for discussion and direction and the local programme team are developing plans to mitigate the risk to the MH&LD service of ePEX becoming unsupported post March 2022.

Assessment and Conclusion

A number of options have been considered including:

- Developing a correction plan to reschedule a WCCIS go LIVE before the end of March 2022
- Upgrade ePEX to EMIS Web
- Implement Version 6 of WCCIS
- Utilise other national systems in the interim, i.e. WPAS

A brief update on these options is provided below:

Reschedule WCCIS go LIVE:

- Fixes have been applied to stabilise the LIVE environment
- National programme plan published that contains timelines for further releases and ABUHB required go LIVE functionality
- Agreement sought to review content of proposed releases and discuss the potential for a March 2022 go-live
- A review of the risks collated following a risk assurance group meeting will be required nationally to enable Service Management Board support for ABUHB on-boarding

Upgrade ePEX to EMIS Web

- Option discounted as EMIS Web does not meet ABUHB inpatient / bed management functionality or Mental Health Act requirements

Implement vn6 of WCCIS

- Gap analysis of functionality undertaken
- An implementation pre-March would not be possible therefore dependent on EMIS contract
- extension beyond March 2022

Utilise other national systems in the interim, i.e. WPAS

- Programme team meeting scheduled W/c 13/12/21 to review functionality against requirements.

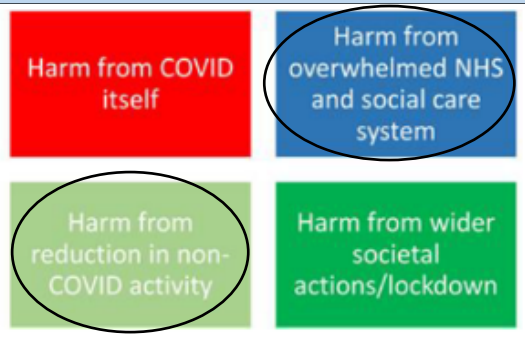
Recommendation
The following next steps and recommendations were agreed at the local programme board meeting on 9th December 2021: • Pursue discussions with EMIS urgently to establish extended support arrangements post March 2022 • Establish a March 2022 go-live window with national programme team and supplier   ○ Conduct detailed re-planning of go-live including training arrangements and undertake risk review to gain support of live organisations for ABUHB on-boarding • Continue to explore any other feasible alternative options and refine associated implementation timelines A further board meeting is scheduled for 17th December 2021 to review progress. The PQSO committee is asked to discuss and support these recommendations in conjunction with the risk assessment of this risk profile.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	A formal programme risk register is in place for the ABUHB WCCIS Programme. It is reviewed at the monthly Programme Board. The WCCIS Programme is included on the corporate risk register. Risks include reputational risk, patient safety concerns, lack of confidence in national delivery timescales and quality of integration being delivered, reduced functionality being accepted for end users and loss of benefits.
Financial Assessment, including Value for Money	Full business case was developed approved by Pre-Investment Panel and at a full ABUHB meeting in May 2017. A dedicated budget has been allocated supported by the Health Board and Integrated Care Fund. Regular budget reviews are undertaken in conjunction with finance department. Benefit identification and realisation plans continue to be an active product within the programme.
Quality, Safety and Patient Experience Assessment	The programme actively monitors National Patient Safety register and the suppliers Hazard Log. The local programme has now established a clinical reference group to review all aspects of quality, safety and patient experience and maintains a local patient safety risk register.
Equality and Diversity Impact Assessment (including child impact assessment)	The business case included commentary that an impact assessment would be undertaken within the programme activities.

Health and Care Standards	3.4 – Information Governance and Communications Technology 3.5 – Record Keeping
Link to Integrated Medium Term Plan/Corporate Objectives	This programme of work has been approved by the ABUHB full Board and has been included in the informatics IMTP. References included in the relevant services Divisional IMTPs.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term** – Patients will be enabled to coproduce their health care using technology to support well-being management, long-term health management and short-term episodes of illness or injury. A digitised framework will be provided within which Practitioners are able to interact with and empower their patients using a wider range of consulting, coaching and informatics skills. Practitioners will have access in real time to all the information they need to treat and care for their patients releasing time to care from non-value adding work.
	Integration – Computing infrastructure will be ubiquitous and information collected joined up and available at each level of the organisation through to population health Patients will enjoy the benefits of integrated information and communication systems operating across primary, secondary and tertiary health care in Wales and across Health and Social Care public sector bodies, third sector and other health care settings.
	Involvement – ABUHB will have engaged leaders who are deeply knowledgeable about the clinical and technological systems in place with Chief Information and Chief Clinical Information Officers in place ensuring a digitally mature approach to service transformation.
	Collaboration – Informatics Directorate will have established long term relationships with academia, technology vendors and suppliers including consortia and small and medium enterprises, social care, third sector and other health organisations, patient representatives and other stakeholders delivering and demonstrating the benefits of innovative uses of informatics to enhance health care.
	Prevention – Informatics Directorate Service Management will provide a sustainable service that prevents and minimises the risk of service disruption and outages to clinical and operational environments through a service and appropriately qualified staff operating within best practice assurance frameworks.
Glossary of New Terms	*WCCIS – Welsh Community Care Information System* *IMTP – Integrated Medium Term Plan*

	MH&LD – Mental Health & Learning Disabilities *ePEX – Current IT solution used by MH&LD service* *EMIS – ePEX supplier*
Public Interest	

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		Risk Description, Appetite and Decision					
• **Enabler risk and links to all priorities**		***CRR020 – (May-2019)*** ***Threat Cause: Failure to implement Welsh Community Care Information System (WCCIS)*** ***Threat Event: Inability to access patient clinical information across all services, departments and partner organisations (such as Local Authority).*** **TREAT**					
High Level Themes	• Patient Outcomes and Experience • Quality and Safety • Reputational • Financial • Public confidence	**Risk Appetite**	There is a high level of appetite for risk on this areas to innovate in the area of digital technologies however, low level risk appetite to maintain patient safety. Therefore the Health Board will ***Treat*** this risk.				
Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Patient Quality, Safety and Outcomes Committee	• Continued engagement with national WCCIS team and Leadership Board and the provider. The Gwent Regional WCCIS Board and ABUHB Programme Board continue to meet and review risks regularly. ABUHB required timescales and critical path imperatives identified. A series of escalation meetings led by SRO have taken place, with the national programme SRO, Programme Director and NWIS.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		2	5	4	5	3	5
Continue to work with the national programme team and Advanced on a timeline for a correction plan. Explore options for MH&LD services to move off ePEX. Understand the impact on later phases of the programme of the current national delays to implementation and work with services to re-plan.	Dec-21	**10**		**20**		**15**	
Trend since last reporting period		**Executive Owner: Director of Planning, Digital and IT**					

Mapping Against 4 Harms of COVID		**Update**
		Dec 2021: Due to national system performance and stability issues, which has impacted on ABUHB go LIVE requirements being delivered by the supplier and national programme, the ABUHB planned implementation for MH&LD services in November has been postponed. The risk remains from a QPS perspective that the EPEX system was due to be unsupported from the end of Dec 21 and has now been extended to March 22. The system is fragile and the absence of an alternative system by March 22 is a patient safety risk and WCCIS cannot be relied upon given current risks and performance issues. An options appraisal was shared with local programme board members for discussion and direction in November. It was agreed to postpone further training on WCCIS for MH&LD services, explore options available including an upgrade to ePEX with the latest EMIS product, engagement with Advanced to look at version 6 of the WCCIS product and explore opportunities to partner with another HB solutions. The local programme team will remain engaged with the national WCCIS programme and aim to bring together a timeline for all options to the next programme board meeting in December 2021 for consideration and agreement on a way forwards.

Highlight Report

Group Name:	**ABUHB Safeguarding Committee**		
Group Aim:	The Committee covers the broad range of Safeguarding activities from prevention to protective intervention on the basis that people have the right to live free from harm and abuse. The Health Board has a zero tolerance approach to the abuse and neglect of adults and children and is committed to working collaboratively and constructively with all relevant agencies to prevent abuse as far as reasonably practicable and to make sure robust arrangements are in place to respond with pace when incidents are witnessed and reported.		
Date Completed:	9th December 2021	**Date of last meeting**	9th December 2021
Completed By:	Rhiannon Jones, Executive Director of Nursing (Chair)		
Distribution List:	• Executive Team • PQSOC		
Summary:	A varied agenda for the December Committee. The Safeguarding Outcomes Report was presented with core data and activity. The Safeguarding Annual Report item focused on the impact for Divisions and their priorities for QTR 4 2021-2022. Sally Jenkins, Director of Social Services attended the meeting to provide an update on the Public Law Working Group - Risks and outcomes. A Child Practice Review was presented.		

Safeguarding Outcomes Report

The Safeguarding Outcomes Report included Quarter 2 data:

Adult & Child Practice Reviews (A/CPR) /Multi-Agency Professional Forums (MAPF) and Domestic Homicide Reviews (DHR)

No new reviews identified and a completed review was presented. It was noted that 2 DHRs are being rewritten due to the quality of the original reports. Ann Hamlet advised that those authors are no longer being used and these issues of quality are being addressed through the Single Unified Safeguarding Review work.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

There were 3 PRUDiC: -

Child 1 - an unexplained infant death. There were no safeguarding concerns identified.
Child 2 – an individual with complex health needs and known to social services. A referral was made to the Regional Safeguarding Board with agreement for a Child Practice Review.
Child 3 – an individual with complex health needs unwell for a few days prior to death. There were no safeguarding concerns identified.

Child Protection Medicals

There have been 67 child protection medicals carried out in this period, a decrease from 77 last quarter figures (45% female: 55% male).

This is the second quarter that has seen a reduction in the number of child protection medicals carried out. In September there was an increase in the numbers of children isolating after return to schools which may be impacting on numbers.

Safeguarding Adult Duty to Reports received

There were 70 Duty to Reports received by the Health Board where there were concerns about care provision. This is an increase from 61 the previous quarter.

The majority of referrals for this period are for Mental Health Learning Disabilities, this is an increase from 14 last quarter figures. Patient to patient assault/abuse has significantly increased from 8 to 17.

There were 13 referrals for Physical abuse, 11 for MH/LD. 9 of which were patient-to-patient assaults.

Safeguarding Training

Level 1 Safeguarding Adult Training - Overall compliance is 69%, which is a decrease from 78% in Quarter 1. Compliance is over 70% in all areas with the exception of Estates and Ancillary staff (65%) and Medical and Dental (22%). It is of note that Estates and Ancillary staff has improved from 55% in Quarter 1. For Medical and Dental staff there has been a decrease from 28%.

Level 1 Safeguarding Children Training - Overall compliance is 77%, which is a 1% decrease from Quarter 1. Compliance is over 80% in all areas with the exception of Estates and Ancillary staff (59%) and Medical and Dental (29%).

VAWDASV Group 1 Training – Overall compliance is 69% which is a 1% decrease from Quarter 1. Compliance is over 70% in all areas with the exception of Estates and Ancillary staff (53%) and Medical and Dental (21%). This is an increase of 6% for Estates and Ancillary and a 2% drop for Medical and Dental.

For Level 2 training this is the first time compliance figures have been extrapolated. The results are disappointing low and Divisions have been asked to develop improvement trajectories.

Level 2 Safeguarding Adult Training - Overall compliance is 40%. Estates and Ancillary staff have the highest level at 58%. Medical and Dental are the lowest at 11%.

Level 2 Safeguarding Children Training - Overall compliance is 23%. Allied Health Professional staff have the highest level at 32%. Healthcare Scientists are the lowest at 10%.

Safeguarding Allegations / Concerns about Practitioners and those in a position of Trust

There have been 28 allegations received in this reporting period, a decrease from the previous quarter. Of these 28 allegations 57% related to HCSWs and 28% RNs. 50% of the allegations have been concluded. 71% of the concluded cases did not meet the threshold.

Safeguarding Risks

As of 30/11/2021 there are 22 risks that have an identified Safeguarding Concern. Of the 22 concerns 8 were overdue for review, which has now reduced to 4.

There are 4 which have a current rating of high risk, with 17 moderate and 1 low risk.

Safeguarding Operational Group exception reporting

Exceptions noted, together with progress with the work plan. The next meeting will focus on options to increase training compliance and using stories to emphasise the importance of a knowledgeable and skilled workforce to ensure robust safeguarding.

Safeguarding Annual Report 2020 2021

Prior to the meeting members had been asked to consider the annual report and the impact for divisions and their priorities for QTR 4 2021-2022.

Themes presented:

- Training, particularly Level 2.
- Aligning Safeguarding Level 3 training
- Awareness of when Duty to Report Required
- Using case examples and scenarios to raise awareness
- The Quality Assurance Framework for Commissioned Services

Public Law Working Group - Risks and Outcomes

Sally Jenkins, Director of Social Services provided an update in relation to Public Law Working Group.

The aim of the review was to understand whether children and young people can be safely diverted from becoming the subject of public law proceedings and ensure that decisions about their lives are made swiftly and fairly before and during proceedings.

There are a number of findings and recommendations all of which rely on closer working relationships between partners to ensure families are offered the appropriate support.

Child Practice Review

Liz Hiscocks Senior Nurse, Governance Lead FATS, presented a Child Practice review into the death of a 2 year old child with complex health needs who died.

Key Learning Themes:

There were three overarching themes identified which have informed the learning points from this review: -

1. Ensuring the needs of the child are given priority
2. Supporting families to fulfil their role as carers
3. Communication

The Report has been accepted by the Regional Safeguarding Board but has not yet been published. The action plan will be monitored via the Regional Safeguarding Board and any local actions will be added to the Corporate Safeguarding Work Plan.

Comment from Chair / Items for Escalation

- Outstanding action from last meeting: FaTS Division to present the Colposcopy SBAR to the Executive Team.
- Level 2 training compliance to be added to the Safeguarding Risk Register, with improvement trajectories developed by Divisions.

Urgent Care Transformation

Month	November 2021

Brief commentary of progress and concerns - CURRENT STATUS – AMBER

The aims of the Urgent Care Transformation Programme are: deliver 24/7 Urgent Primary Care provision and improvement, Improve Emergency Care performance, and deliver an effective Graduated Care service – admission avoidance.

ECIB – **SDEC -** 7 month building re-work commenced 8th Nov 2021. Agile Floor 1 move to Level 2 and MRI complete. A working group will be established to plan the All Grange site offering for Agile, rest/break and break out space. **Flow Centre** - established a number of key pathways notably chest pain, head injury and minor injury. **ED Improvement** – Wait area information screens in process Interim SDEC offering to be discussed with Medicine re capacity **Integrated front Door** – Getting closer to BUA, work to start reviewing how we replicate at GUH. **Discharge & Transfer improvement** to be a focus of 20/21st Nov.

Urgent primary Care – 111 Call volumes remain low and decreasing, high abandonment rate, WAST recruiting further call handlers, UPC can offer limited support on picking up 111 calls, Supporting ED with admin support for re-directions from GUH.

Graduated Care – Direct admission pathways continues. Care home conveyancing work stream started. 20,000 project commenced to identify patients at risk. Additional resources agreed for reablement.

Positive progress

- SDEC Building work started
- Flow centre Pathways
- Direct admission pathways
- COTE Working group (key interdependency)
- UCTB Survey completed highlighting views of priorities

Concern areas / help required

- System improvement benefit realisation
- 111 Capacity / Communications
- Winter planning impact to ED improvement work

Interdependencies with other workstreams

- COTE
- WAST
- Outpatients
- UPC

Forward plans next month

- Use survey to prioritise the projects
- Focus on the near term projects that can affect this winter
- Begin setting the standard for quantifying progress / improvements

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient, Quality, Safety and Outcomes Committee Tuesday 21st December 2021 Agenda Item: xx

Aneurin Bevan University Health Board
Strategic Risk Report

Executive Summary

This report provides an overview of the profile of the current most significant risks to be reported to the Patient, Quality, Safety and Outcomes Committee (PQSOC). The risks reflect the continuing challenges of the COVID pandemic along with restart and recovery of previously paused operational services and ongoing uncertainties related to Variants of Concern (VoC).

The PQSO Committee is asked to note this report for assurance.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor:	Rani Mallison, Board Secretary
Report Author:	Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by :

Executive Team	**N/A**	**Committee of the Board [Patient, Quality, Safety and Outcomes Committee]**	**As outlined.**

Date of the Report: 1st December 2021

Supplementary Papers Attached:
Appendix 1 – Summary of Risk Profiles

Purpose of the Report

This report is provided for assurance purposes and seeks to provide a summary of the current key risks to the Health Board in respect of Quality and Patient Safety.

Background and Context

In conjunction with the revised Board Assurance Framework (BAF) and the revised Risk Management Approach, the Health Board is able to review and assess its strategic risks against achievement of objectives as set out in the Annual Plan 2021/22.

This report provides the Patient Quality, Safety and Outcomes Committee with an opportunity to review the organisational strategic risks which receive oversight from PQSO Committee.

The Health Board utilises the All Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy.

Assessment & Overview of Current Status

The revised risk management approach remains in the embedding phase throughout the organisation and thematic alignment can be evidenced through the Divisional risk reporting and strategic risk profile reporting. Continued engagement throughout the organisation has taken place to strengthen the utilisation of the Health Board's internal electronic risk management system (DATIX). The risk management system will form one of the key sources of business intelligence in respect of identification and escalation of operational risk, in conjunction with Executive level horizon scanning led risk identification.

Evidence to suggest that the revised risk management approach continues to embed is clear as two of the risk profiles included in this report have been escalated operationally, utilising the internal risk management system.

Further development work alongside Divisions is being undertaken to ensure risks are being captured on the system appropriately and consistently in terms of scoring, risk assessment and descriptors. This work is underpinned and supported by Executive Team which provides an overarching position in relation to each risk area. In parallel to horizon scanning, strategic risk identification, the Health Board's risk management approach and infrastructure, is continually improving.

Current Status

The Committee is asked to note the current status of the 14 strategic risks which receive oversight from the Committee:

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Risk Treatment
CRR019 Emergency Care	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.
CRR002 Workforce	20	10	**Low** level of risk appetite in relation to potential patient safety risks. **Moderate** levels of risk with regard to innovation and changing roles to attract more staff and	**Treat** the impact of the risk by using internal controls.

			deliver services in different ways through new roles.	
CRR013 Infection Prevention and Control	15	10	**Zero or low** due to patient safety and quality of service.	**Treat** the potential impacts of the risk by using internal controls.
CRR020 WCCIS	20	15	**High** level of appetite for risk on this areas to innovate in the area of digital technologies. **Low** level risk appetite for the realisation of this risk and to maintain patient safety.	**Treat** the potential impacts of the risk by using internal controls.
CRR023 Avoidable harm due to COVID	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.
CRR007 Aging Population	16	12	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and some are out of the Health Board's control.
CRR010 Inpatient Falls	15	10	**Zero or low** in the interests of patient safety.	**Treat** the potential impacts of the risk by using internal controls.
CRR027 Variant of Concern	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.

			is beyond the Health Board's control.	
CRR028 Inappropriate admissions of Children and Young People to adult mental health in-patient beds	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**Treat** the potential impacts of the risk by using internal controls.
CRR030 Safeguarding	16	5	**Low** risk appetite in this area due to potential impact on quality, experience and patient outcomes.	**Treat** the potential impacts of the risk by using internal controls.
CRR031 RSV	10	6	**Low** risk appetite in this area due to the recognised fragility of Paediatric services.	**Treat** the potential impacts of the risk by using internal controls.
CRR001 Flu Vaccination	8	8	**Low** level of risk appetite in relation to patient experience. **Moderate** levels of risk appetite can be applied to pursue innovative models and technologies to encourage uptake.	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.
CRR003 Capacity of Mental Health Services	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.
CRR026 Inadequate Surge Capacity ***links to Workforce risk – CRR002**	20	5	**Low** risk appetite level will be applied.	**Treat** the potential impacts of the risk by using internal controls.

We will be actively working to review risk targets to ensure realistic and as far as possible; set within the context of the Board's appetite for risk.

From an organisational-wide risk management perspective, an assessment has been undertaken on the Divisional risk registers held on the internal risk management system, DATIX. The assessment indicated that a number of risks patient safety risks related to

Urgent Care. In light of this information the Emergency Care risk was re-framed to reflect the following:

CRR019 – (Nov 2021) Re-framed
4 x 5 = 20
Threat Cause: Significant delayed transfers of care, domiciliary and care home constraints and inappropriate presentations to Emergency Department.
Threat Event: Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand.

It was agreed that the revised risk descriptor more accurately described the current position.

Following a request from the Chair of PQSO Committee to focus on mission critical risks with most significant impact, an assessment was undertaken to determine the highest level impact of risks.

Given the intelligence held internally; risks being reported operationally via the DATIX risk management system, it was concluded to be appropriate to include the Emergency Care risk. In addition to this and as a common theme across all Divisions, it was agreed to include the Workforce risk specifically impacting on inability to safe and effective care[1]. From an Executive, horizon scanning position, it was agreed to include the Variant of Concern (VoC) risk and the WCCIS risk. In relation to the WCCIS risk profile, the Committee is asked to note the EPEX system was due to be unsupported end of December 2021 however, this has now been extended to March 2022. The system remains very fragile and in the absence of an alternative system by March 2022 this is potentially a patient safety risk and WCCIS cannot be relied upon given current risks and performance issues.

A high level breakdown of these 4 risk profiles are included overleaf and a detailed update on each is included as part of this report at ***Appendix 1***.

Risk Description	Risk Score	Risk Owner	Trend
CRR019 – (Nov 2021) Re-framed Emergency Care	**4x5 = 20**	Director of Operations	
CRR027 (June - 2021) Variant of Concern	**5x5 = 25**	Director of Public Health and Strategic Partnerships	

1. The Committee is asked to note that Divisional risk refers to operational Divisions not enabler directorates such as workforce, ICT and Finance. It is anticipated that these directorates will begin to utilise DATIX next financial year when the new risk management module is launched.

CRR020 – (May-2019) WCCIS	**4x5 = 20**	Director of Planning, Performance, Digital and ICT	
CRR002 (March-2017) Inadequate Workforce to provide appropriate care	**4x5 = 20**	Director of Workforce and Organisational Development	

In light of the current pandemic position and escalations in relation to the recent development of Omicron, the VoC risk profile is reported as an escalating risk alongside the surge capacity risk. The in-patient falls risk has decreased in light of the positive performance across all hospital sites in relation to a reduction in in-patient falls. All other risk profiles remaining static since the last reporting period.

The Health Board will endeavour to develop a Committee work plan which will be informed by:

- Terms of reference
- Risks relevant to the Committee
- Any gaps or perceived gaps in assurance, based on information held in the Board Assurance Framework

This will be presented back to the Committee for consideration in the New Year.

Recommendation & Conclusion

The Committee is asked to note the content of this report for assurance purposes, recognising that there will be further iterative development work to embed the revised risk management approach with QPSOG and Divisions.

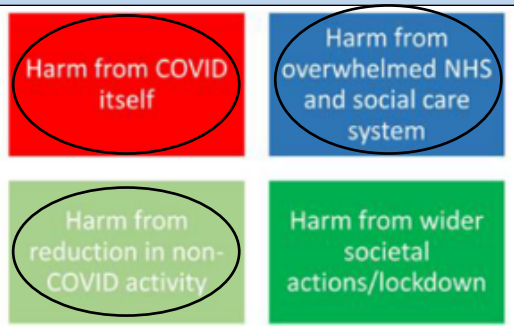
Supporting Assessment & Additional Information

Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment (including value for money)	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety & Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality & Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.

Health & Care Standards	This report contributes to the good governance elements of the H & CS.
Linked to Integrated Medium Terms Plan & Corporate Objectives	The objectives will be referenced to the IMTP
The Wellbeing of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of Terms	None
Public Interest	Report to be published

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">• Getting it right for children and young adults
• Supporting adults in Gwent to live healthy and age well
• Provide high quality care and support for older adults
• Staying healthy
• Care closer to home
• Less serious illness that require hospital care
• Dying well</td><td colspan="3">CRR019 – (Nov 2021) Re-framed
Threat Cause: Significant delayed transfers of care, domiciliary and care home constraints and inappropriate presentations to Emergency Department.
Threat Event: Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand.
TREAT TOLERATE</td></tr>
<tr><td>High Level Themes</td><td>• Patient Outcomes and Experience
• Population Health
• Quality and Safety
• Reputational
• Public confidence
• Financial</td><td>Risk Appetite</td><td colspan="2">Low level of risk appetite in relation to patient safety risks. However, moderate levels of risk with regard to innovation and changing models of care and roles to prevent demand and better to demand. Therefore the Health Board will seek to Treat and Tolerate this risk within agreed and specified tolerance/capacity levels.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>Patient, Quality, Safety and Outcomes Committee</td><td>• Health Board Emergency Pressures Escalation Policy (revised Nov 2021)
• Health Board surge plans.
• Health Board SLA with WAST
• System Leadership and Response – whole system planning – meets x3 weekly.
• Cross-site meetings to discuss system and flow pressures meets x3 daily.
• Emergency Care Improvement Board – meets monthly
• Discharge Improvement Board – meets monthly
• Urgent Care Transformation Board</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***		**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
			4	5	4	5	3	5
Short Term: • Piloting new pathways in the flow-centre • Public messaging including social media to ask the public to consider other options before attending the Emergency Department. These messages have been shared through partner organisations, the Health Board website and social media channels. • System reset weekend – planned for weekend of 20th and 21st November • RRV pilot - consultant providing advice around potential admission and/or admission avoidance utilising enhanced observations. • Respiratory Ambulatory Care Unit go live - phase one consultant to identify suitable patients, phase two Flow Navigator • Trial of Front Door Frailty at GUH • Review and amendment of escalation plan and approach • Discharge improvement Board – Criteria Led Discharge SOP for all HCP's • GP/HCP - one single point of access for GP to arrange admission and book transport. • Continued GP aligned to the Flow Centre triaging patients on the ambulance stack, redirecting patients to appropriate pathways and services following a request for an emergency response by contacting 999 • Home First service extend focus to ED at the GUH to ensure that those people who are able to be re-directed or are able to use Direct conveyance to community beds • Care home conveyance - Highest reasons for calls/conveyance is falls/injury from fall – response will be co-ordinated • High Risk Adult Cohort (Venn diagram) – pilot project, multiagency group building on existing compassionate communities framework to ensure that those individuals who have been in hospital in the last year have health review and plan in place • Table top exercises have commenced between MIU/UPCC/111 to ensure the 111 Algorithm is directing patients to the right places, this work has suggested there is further improving to the numbers of patients directed towards UPCC , size of opportunity currently being quantify.		Ongoing Ongoing Nov-2021	**20**		**20**		**15**	

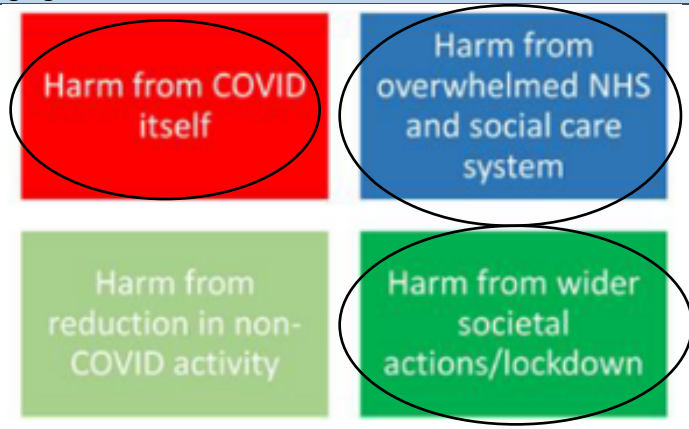
• Implementation of Trauma assessment unit in GUH site **Medium Term (3-12 months)** • Development of the SDEC bid on the GUH site • Step closer to home pathway • Integrated Front Door proposal at Nevill Hall • Pilot of complex discharge planning app	Spring 2022			
Trend since last reporting period		**Executive Owner: Director of Operations**		
Mapping Against 4 Harms of COVID		**Update**		
		Dec 2021 The Health Board continues to work alongside the Delivery Unit to maximise discharges, this includes engagement with Senior Nurses, discharge co-ordinators and relatives/family members. Continued population engagement on accessing most appropriate services, at the right place, at the right time and teams at the GUH are continuing to have sensitive conversations with family members regarding discharges. A number of Health Board initiatives are underway and regular reviews are undertaken to understand benefits and extract learning. HIW has recently carried out an inspection of the GUH emergency care department and immediate recommendations have already been implemented. The full report and set of recommendations are awaited and updates will be provided in due course. SDEC care currently being delivered in Respiratory and Gastroenterology with the potential to increase patients being treated there if pts can be streamed from Flow Centre. Build has commenced for dedicated SDEC in GUH site that will incorporate surgery and acute medicine in Summer of 2022. Recruitment for permanent staff in readiness for summer is being progressed, ahead of the full development being available. AP workforce remains particularly challenging to deliver this without withdrawing from other sites over winter but will continue to assess. Outcome of System Re-set weekend – significant system benefits were seen over the weekend and this was down to a number of factors. The outcome of the weekend currently in the process of being typed up and to be shared with the Exec team about what we should prioritise for WF supply and embed in our system over winter and beyond. In particular initiatives that work included (but is not exhaustive): • 7 day cover for pharmacy and therapies • Input of home first on the weekend • Roving team of Physicians Associates to support discharge • Focus on discharge not step down • GUH Frailty model		

<table>
<tr><td colspan="3">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="5">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="3">Priority 2- Getting it right for children and young adults
Priority 3 – Adult in Gwent live healthy and age well
Priority 4 – Older adults are supported to live well and independently</td><td colspan="5">CRR027 (June - 2021)
Threat Event: Effectiveness of COVID-19 vaccination and booster programme compromised
Threat Cause: - New Variants emerge

TREAT TOLERATE</td></tr>
<tr><td>High Level Themes</td><td colspan="2">• Patient Outcomes and Experience
• Quality and Safety
• Reputational
• Public confidence
• Staff Well Being</td><td>Risk Appetite</td><td colspan="4">Given the unpredictability of the potential of variants of concern, a flexible, moderate risk appetite level will need to be applied to this risk profile. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control. Therefore an element of this risk will need to be tolerated.</td></tr>
<tr><td>Committee Assurance</td><td colspan="2">Internal Controls – Policies/Procedures</td><td colspan="5">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td colspan="2">• IMTs controlling clusters and outbreaks and keeping cases as low as possible.
• Gwent IMT with SBAR (reported weekly to Executive Team)
• Keeping abreast of guidance from WG.
• Continuing public messaging on adherence to restrictions.
• Vaccination Programme Board monitoring roll-out of programme weekly.</td><td colspan="2">Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td colspan="2">Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
<tr><td colspan="2">Action Plan SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.</td><td>Due Date</td><td>Likelihood</td><td>Consequence</td><td>Likelihood</td><td>Consequence</td><td>Likelihood</td><td>Consequence</td></tr>
<tr><td colspan="2"></td><td></td><td>5</td><td>5</td><td>5</td><td>5</td><td>4</td><td>5</td></tr>
</table>

Gwent IMT leads on multi agency response to manage community response with weekly sit reps (SBAR) to WG. Gwent IMT involves representatives from 5 x Local Authority Directors of Public Protection, ABUHB Director of Public Health, & Public Health Wales Health Protection. Gwent IMT & Gwent, TTPS delivery and management of National VAMC guidance, regional testing plans etc. Continual review and updating of Gwent Covid-19 Prevention and Response Plan, transition to Recovery Coordination Groups inclusive of VoC related exercises.	Monitored weekly at present	**25**	**25**	**20**

Trend since last reporting period	↑
Executive Owner: Director of Public Health and Strategic Partnerships	
Mapping Against 4 Harms of COVID	**Update**



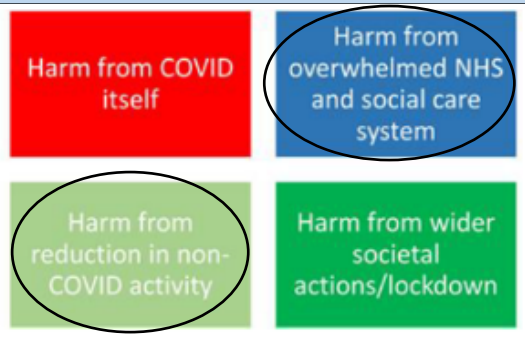
Dec 2021:

It is not known yet if the Omicron variant will out compete the Delta variant due to being more transmissible, able to escape existing immunity (natural or vaccine induced) or both combined. The pattern of confirmed cases of the Omicron VoC in England and Scotland means that cases are expected to occur in Wales too.

The strategy is to slow spread of Omicron as much as feasibly possible, to gain time to accelerate the vaccination booster programme and to obtain data to develop predictive models to inform the policy response and local planning. Genomic sequencing of positive tests and incident management team arrangements continue to be in place across the ABUHB area to detect and organise control measures to reduce spread of the Omicron variant as long as reasonably possible.

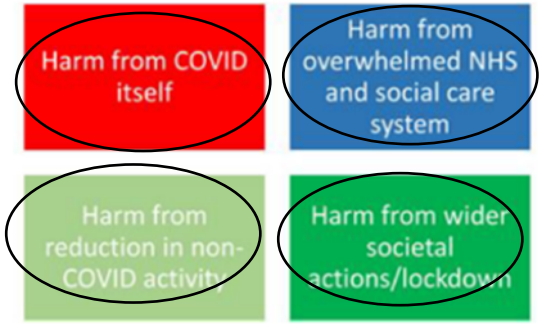
All the COVID-19 vaccines in use in Wales continue to be effective at reducing the risk of serious illness, hospitalisation and death following infection with the Delta variant. Vaccine uptake rates in the Health Board area continue to be high as reported in the weekly newsletter. The effectiveness of the current vaccines against the Omicron variant is as yet unknown.

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="4">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">• Enabler risk and links to all priorities</td><td colspan="4">CRR020 – (May-2019)
Threat Cause: Failure to implement Welsh Community Care Information System (WCCIS)
Threat Event: Inability to access patient clinical information across all services, departments and partner organisations (such as Local Authority).
TREAT</td></tr>
<tr><td>High Level Themes</td><td>• Patient Outcomes and Experience
• Quality and Safety
• Reputational
• Financial
• Public confidence</td><td>Risk Appetite</td><td colspan="3">There is a high level of appetite for risk on this areas to innovate in the area of digital technologies however, low level risk appetite to maintain patient safety. Therefore the Health Board will Treat this risk.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>• Continued engagement with national WCCIS team and Leadership Board and the provider. The Gwent Regional WCCIS Board and ABUHB Programme Board continue to meet and review risks regularly. ABUHB required timescales and critical path imperatives identified. A series of escalation meetings led by SRO have taken place, with the national programme SRO, Programme Director and NWIS.</td><td colspan="4">Inherent Risk level before any controls/mitigations implemented, in its initial state.
Current Risk level after initial controls/mitigations have been implemented.
Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
<tr><td colspan="2">Action Plan SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.</td><td>Due Date</td><td>Likelihood
2</td><td>Consequence
5</td><td>Likelihood
4</td><td>Consequence
5</td></tr>
<tr><td colspan="2">Continue to work with the national programme team and Advanced on a timeline for a correction plan.
Explore options for MH&LD services to move off ePEX.
Understand the impact on later phases of the programme of the current national delays to implementation and work with services to re-plan.</td><td>Dec-21</td><td colspan="2">10</td><td colspan="2">20</td></tr>
<tr><td colspan="2">Trend since last reporting period</td><td colspan="2">⟷</td><td colspan="4">Executive Owner: Director of Planning, Digital and IT</td></tr>
</table>

Mapping Against 4 Harms of COVID		**Update**
		Dec 2021: Due to national system performance and stability issues, which has impacted on ABUHB go LIVE requirements being delivered by the supplier and national programme, the ABUHB planned implementation for MH&LD services in November has been postponed. The risk remains from a QPS perspective that the EPEX system was due to be unsupported from the end of Dec 21 and has now been extended to March 22. The system is fragile and the absence of an alternative system by March 22 is a patient safety risk and WCCIS cannot be relied upon given current risks and performance issues. An options appraisal was shared with local programme board members for discussion and direction in November. It was agreed to postpone further training on WCCIS for MH&LD services, explore options available including an upgrade to ePEX with the latest EMIS product, engagement with Advanced to look at vn 6 of the WCCIS product and explore opportunities to partner with another HB solutions. The local programme team will remain engaged with the national WCCIS programme and aim to bring together a timeline for all options to the next programme board meeting in December for consideration and agreement on a way forwards.

<table>
<tr><th colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</th><th colspan="3">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">• Enabler risk and links to all strategic priorities</td><td colspan="3">TREAT
CRR002 (March-2017) –
Threat Event: Inability to delivery high quality care
Threat Cause: Failure to recruit and retain appropriately skilled staff and senior leadership</td></tr>
<tr><td>High Level Themes</td><td>• Patient Outcomes and Experience
• Population Health
• Quality and Safety
• Reputational
• Public confidence
• Finance
• Workforce</td><td>Risk Appetite</td><td colspan="2">Low level of risk appetite in relation to potential patient safety risks. However, moderate levels of risk with regard to innovation and changing roles to attract more staff and deliver services in different ways through new roles, therefore the Health Board will seek to Treat this risk profile.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="3">Risk Score</td></tr>
<tr><td>People and Culture Committee</td><td>• Workforce Dashboard to track appointments against plan
• RN Supply and Demand Tracker to review nursing vacancies, turnover and demand.
• Recruitment plan to support winter
• Mass vaccination programme updates reporting to Mass Vaccination Board and Executive Team.
• Redeployment Principles and Risk Assessment.
• Workforce and OD hub to support winter pressures
• Management of attendance through Sickness Absence Policy
• Health care Standards - Section 7 staffing and resources
• Nurse Staffing Levels (Wales) Act 201625b/25c
• Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e. RCP
• Agile Working Delivery Board
• Measurements of Wellbeing &” People First-Staff Engagement” Strategies</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	5	4	5	3	5
• Workforce projections, plans and scenarios take account of increased absence and workforce availability based on previous trends • Continue to align workforce modelling to bed plans • Aligning resources to bed plan and recovery plans to demonstrate staffing across sites • Continue to review overarching deployment plan, reviewed staffing models for ward areas, increasing supply through agency block booking. • Agree Bank worker pay incentives and enhanced overtime rates to encourage additional hours from all staff groups. • Recruitment plans underway for winter period • Continuing support for staff who are absent and self-isolating to support well-being and a safe return to work • Recruit additional HCSW and recruitment for apprenticeships and Kick Start programmes • Utilise European Gateway and BAPIO for medical recruitment aligned to safe staffing review in Medicine Specialties. • Personal Development Planning for staff members, including opportunities post TTP • Application of recovery rates of pay for Medical and Dental and Agenda for Change staff to support additional activity • Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for registered nurses, physician's associates, midwives, and therapy staff and with HEIW for junior doctor. • Continued implementation of new roles such as Physician Associates and Associate Practitioner (Nursing) to support workforce skills gaps in line with Annual Plan • Registered Nurse Recruitment Programme of events with Train, Work, Live and RCN • Specific recruitment programmes for COVID surge and mass vaccination responding to the increase in demand for staff as a result of COVID pandemic. Extend fixed term contract extensions for TTP/mass vaccination • Development of Hybrid Medical Roles to work across Specialities • Introduction of new Specialist Grade role to support Senior Medical vacancies • Including review of benefits of COVID support roles. Opportunities to provide new roles to support clinical teams, e.g. volunteer activity co-ordinators, roster creators, ward assistants • Increase apprenticeship and work experience routes, including DWP Kick Start Scheme, with a focus on widening access for minority ethnic group and people with protected characteristics.	Mar-22	**25**		**20**		**15**	

• People First Staff Engagement Framework in place to support retention and Staff Well-being medium and long term plan to support retention including well-being staff surveys, peer support, increase in psychology support through investment in the service to support stage 2 of the Well-being Centre of Excellence and the development and piloting of a Trauma Step Care Model is enabling individual and team needs to be assessed and supported. • Workforce planning guidance in place to assess turnover, retirements and succession planning to inform educational commissioning requirements. • Continue to monitor safe staffing levels (periodically) as part of the Safer Staffing act section 25 reported via Executive Director of Nursing • Securing mutual aid where possible		
Trend since last reporting period		**Executive Owner: Director of Workforce and Organisational Development**
Mapping Against 4 Harms of COVID		**Update**
		**Dec 21:** • Significant work undertaken in relation to recruitment and retention i.e. Staff Retention Framework and winter workforce plans developed and being reviewed against bed plans and demand for appropriate action. Currently recruiting to Resource bank for winter planning and mass vaccination • 7 sessions of people First staff Engagement Strategy completed • Programme of equality events rolled out to support retention Expanded number of agencies we are working with to increase supply of agency resources • Recruited 8 doctors from European Gateway and 2 doctors from BAPIO • Interviews in progress for apprentices and Kickstart placements with start dates planned for November. • 78 HCSW currently progressing through PECs to support winter pressures with a further 43 WTE to be recruited. • Over 35 WTE Block Bookings secured for Winter • 234 newly qualified students are in the process of joining ABUHB. As of end of November 60 have completed checks (which includes 42 nurses) and are in the process of confirming start dates. The checks for the remaining 174 are currently being expedited. • Bank worker pay incentives and enhanced overtime rates have been agreed and to encourage additional hours from all staff groups. • Actively working with local authorities to promote joint recruitment activities • Additional 188 HCSW recruited since April 2021 • Fast track recruitment process for staff returners • Absence reducing with “hot spot” areas identified and plans in place to support • Launch of apprenticeship and employability schemes to encourage diverse community representation, with 33 apprentices recruited in the first cohort. • recruited 12 with 4 in interview through Kickstart scheme

	• Review undertaken of medical staffing establishment and the development of a medical recruitment strategy to recruit an additional 21 doctors. • Roll out of touring winter recruitment event • Engagement with universities to promote adhoc paid working opportunities for medical and nursing students. • Ongoing discussions with student streamlining (e.g. nursing, AHP's and PA's) programmes to promote opportunities within ABUHB. • The Mass Vaccination Programme continues to review the workforce required to deliver the COVID-19 vaccinations. Recruitment and training continues with additional training provided to support the immunisation of children. Additional resources to be on-boarded to support WOD with the ongoing requirements of management of training sessions and delivery of online learning. • Continuing to review opportunities to increase capacity in new roles developed to support initial Covid response such as patient care assistants, ward assistants and roster coordinators for future service winter demands. Plan to undertake local recruitment events in partnership with social care/local authorities in development. • New Specialist Grade available for recruitment and progressing with the transition of current Speciality Doctors to the new contract. • Recruit to Medical workforce Safe Staffing requirements approved to support recruitment to additional roles in Medicine Division. Recruitment Strategy in place • Appointment of PA posts secured via student streamlining • Agreement to continue with local enhanced rates in specific areas